Trinity Term
[2023] UKSC 20

On appeal from: [2020] EWCA Civ 738

JUDGMENT

R (on the application of Maguire) (Appellant)

v

His Majesty's Senior Coroner for Blackpool & Fylde and another (Respondents)

before

Lord Reed, President
Lord Lloyd-Jones
Lord Sales
Lord Stephens
Lady Rose

JUDGMENT GIVEN ON
21 June 2023

Heard on 22 and 23 November 2022

Appellant
Jenni Richards KC
Nicola Kohn
(Instructed by Bindmans LLP (London))

Respondent (His Majesty's Senior Coroner for Blackpool & Fylde)
Jason Beer KC
Sophie Cartwright KC
(Instructed by Corporate Legal Services Blackpool Council)

Interested Party
Kenneth Maguire
(appearing in person)

First Intervener
Alex Ruck-Keene KC (Hon)
Jake Thorold
(Instructed by MIND)

Second Intervener
Paul Bowen KC
(Instructed by Equality and Human Rights Commission)

LORD SALES (with whom Lord Reed, Lord Lloyd-Jones and Lady Rose agree):

1. This case is concerned with the conduct of an inquest into the death of Ms Jacqueline Maguire, aged 52, in hospital on 22 February 2017 from pneumonia and a perforated gastric ulcer and peritonitis and the impact upon this of article 2 of the European Convention on Human Rights ("the Convention"). Article 2 is a convention right set out in the Human Rights Act 1998 ("the HRA"). I will refer to Jacqueline Maguire as "Jackie", as her family has requested.

2. Article 2 provides, so far as is relevant, that "Everyone's right to life shall be protected by law". It is established law that this provision has a substantive aspect, governing the ways in which the state should act to protect life, and a procedural aspect, which imposes an obligation on the state to provide for investigation as to whether a death may have resulted from a breach of the substantive obligations imposed by article 2. The precise content of the substantive obligations and of the procedural obligation under article 2 varies depending on the circumstances of a particular case. In this appeal, both the substantive aspect and the procedural aspect of article 2 are in issue.

3. Section 1 of the Coroners and Justice Act 2009 ("the 2009 Act") provides that where a senior coroner has reason to suspect that a deceased person whose body is within their area died a violent or unnatural death, the cause of death is unknown or the deceased died while in custody or otherwise in state detention, the coroner must conduct an investigation into the person's death. The respondent ("the Coroner") decided that the investigation into Jackie's death should take the form of an inquest conducted with a jury. The specific question which arises for determination in these proceedings is whether the circumstances surrounding the death of Jackie required the Coroner to request the jury at her inquest to return an expanded verdict in accordance with section 5(2) of the 2009 Act. Section 5 provides:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain -
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act [the Births and Deaths Registration Act 1953] to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than -
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);

(b) the particulars mentioned in subsection (1)(c)."

Section 10(2) of the 2009 Act provides that a determination under section 5 "may not be framed in such a way as to appear to determine any question of - (a) criminal liability on the part of a named person, or (b) civil liability".

4. The answer to the question arising as to the form of verdict to be delivered pursuant to section 5 depends upon the effect of article 2 in the circumstances of the inquest into Jackie's death. If article 2 requires an expanded verdict to describe the circumstances in which Jackie came by her death, then section 5(2) comes into play and the usual limitations in section 5(1) regarding the form of verdict do not apply.

5. The Coroner commenced the inquest into Jackie's death on the basis that it was likely that article 2 would require an expanded verdict at its end, but recognising that in its course matters might be sufficiently ventilated and clarified so that article 2 would no longer require this. Jackie's family were represented by counsel at the inquest, as were all the other interested persons. At the close of the evidence in the inquest hearing the Coroner invited submissions from the interested persons, including Jackie's family, as to the form of verdict which the jury should be asked to return. In the light of those submissions, on 29 June 2018 the Coroner gave his decision that article 2 did not require an expanded verdict ("the verdict decision"). Therefore the jury was requested to give a short form verdict stating only the cause of Jackie's death. Whether the verdict decision was correct in law is under challenge in these proceedings.

6. This claim for judicial review of the verdict decision has been brought by Jackie's mother, Mrs Muriel Maguire. Jackie's brother, Mr Kenneth Maguire, has participated in the proceedings as an interested party.

7. This judgment is structured as follows:

(1) An outline of the applicable legal framework for the inquest under article 2, including the substantive positive obligations under article 2 in the form of the systems duty and the operational duty and the different aspects of the implied procedural obligation under article 2, in order to explain the context for the verdict decision: paras 8-24;

(2) The 2009 Act and the requirement for an expanded verdict: paras 25-33;

(3) Development of the substantive positive obligations under article 2 by the European Court of Human Rights ("the Strasbourg Court") in the cases of *Osman*, *Powell* and *Calvelli*: paras 34-39;

(4) The leading Strasbourg cases of *Fernandes* and *Oliveira* on the substantive positive obligations under article 2 in the field of healthcare and care of vulnerable people: paras 40-62;

(5) The facts of this case: paras 63-114;

(6) The judicial review proceedings in the Divisional Court and the Court of Appeal: paras 115-134;

(7) Discussion of the issues in the appeal (paras 135 and following): (a) was there an arguable breach of the systems duty on the part of the care home, so as to trigger the enhanced procedural obligation under article 2 (paras 144-181)? (b) was there an arguable breach of the systems duty on the part of any of the healthcare providers so as to trigger that obligation (para 182-184)? (c) was there an arguable breach of the operational duty on the part of the care home so as to trigger that obligation (paras 185-204)? and (d) was there an arguable breach of the operational duty on the part of any of the healthcare providers, so as to trigger that obligation (paras 205-209)?

(8) The effect on the appellant's case of general reports (the LDM Review and the CIPOLD report) on health outcomes for individuals with learning difficulties and lack of capacity: para 210; and

(9) The *Ullah* principle: para 211.

The overall conclusion is given at para 212.

(1) Article 2: outline of the applicable legal framework

8. At the outset it is helpful to set out an outline of the applicable legal framework within which the inquest took place, because it sets the scene to explain the decisions taken by the Coroner, culminating in the verdict decision. I will analyse the position in more detail later on.

9. In addition to prohibiting certain conduct, article 2 imposes a positive obligation on contracting states to take "appropriate steps to safeguard the lives of those within [their] jurisdiction", as the Strasbourg Court put it in *LCB v United Kingdom* (1998) 27 EHRR 212 ("*LCB*"), at para 36. This is a very general statement and the various aspects and specific content of this positive obligation have been clarified in a substantial body of case-law both in Strasbourg and domestically.

10. It has been held that article 2 imposes certain substantive positive obligations on a state to take steps to protect life. These are typically analysed as being of two types, an obligation to have appropriate legal regimes and administrative systems in place to provide general protection for the lives of citizens and persons in its territory ("the systems duty") and an obligation to take operational steps to protect a specific person or persons when on notice that they are subject to a risk to life of a particularly clear and pressing kind ("the operational duty").

11. The distinction between these two types of substantive positive obligation has been emphasised at the highest level in the domestic case-law and the Strasbourg case-law: *Savage v South Essex Partnership NHS Trust* [2009] AC 681 ("*Savage*"), paras 18-24, 40-42 and 67-72 (Lord Rodger of Earlsferry) and paras 77-79 (Baroness Hale of Richmond); *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72 ("*Rabone*"), para 12 (Lord Dyson) and paras 93-94 (Baroness Hale); *Lopes de Sousa Fernandes v Portugal* 66 EHRR 28 ("*Fernandes*"), GC, paras 166-167 and 191-192; and *Fernandes de Oliveira v Portugal* (2019) 69 EHRR 8 ("*Oliveira*"), GC, para 103. As it was put in *Oliveira*, these are "distinct albeit related positive obligations under article 2". The operational duty derives, in particular, from the judgment of the Strasbourg Court in *Osman v United Kingdom* (1998) 29 EHRR 245 ("*Osman*").

12. In addition, article 2 imposes certain positive obligations of a procedural nature regarding investigation of and the opportunity to call state authorities to account for potential breaches of the substantive obligations to which it gives rise. The precise content of the procedural obligation on a state varies according to the context in which an issue regarding the application of article 2 arises. There is no simple monolithic form of procedural obligation which applies in every such case. Rather, the procedural obligation applies in a graduated way depending on the circumstances of the case and the way in which in a particular context the state may be called upon to provide due accountability in relation to the steps taken to protect the right to life under article 2. The graduated way in which the procedural obligation applies reflects the fact that this obligation, like the substantive positive obligations under article 2, is an implied positive duty which is not to be taken to impose an unreasonable or disproportionate burden upon the state.

13. For the account which follows, I have derived assistance from the meticulous judgment of Popplewell LJ in *R (Morahan) v West London Assistant Coroner* [2021] EWHC 1603 (Admin); [2021] QB 1205 ("*Morahan*"); on appeal, the decision was upheld in a short judgment which approved the reasons given by Popplewell LJ: [2022] EWCA Civ 1410; [2023] 2 WLR 497, paras 41-42. *Morahan* contains a detailed review of the relevant case-law and what I consider to be a compelling analysis of the law in this area. Counsel for the appellant, Ms Jenni Richards KC (who did not appear below) began her oral submissions by referring to *Morahan* as part of the relevant framework to locate the submissions she was to make and did not seek to criticise Popplewell LJ's judgment. Mr Jason Beer KC, for the Coroner, also referred to it. I have found it particularly helpful to be able to refer to *Morahan* in the circumstances of this appeal, in which the court has been hampered by the absence of adversarial argument from the Coroner or any other interested party, for reasons explained below. *Morahan* came after the judgment of the Court of Appeal in the present case, to which Popplewell LJ referred. However, his reasoning is predominantly based on an analysis of previous domestic decisions at the highest level and relevant Strasbourg case-law.

14. For present purposes three different levels of the graduated procedural obligation may be identified in relation to investigation of a death. First, at the most basic level, in order to check whether there might be any question of a potential breach of a person's right to life under article 2, state authorities should take some steps to establish whether the cause of death is from natural causes rather than, say, as a result of criminal means such as violence or other foul play ("the basic procedural obligation"). If a dead body were found in the street, just as much as if a prisoner in custody dies, a state would need to check the cause of death to see whether steps might have to be taken to apply the relevant criminal or other law which is in place as part of the system to provide protection for life, or whether the framework in place to protect life is deficient: *Morahan*, paras 92 and 122(1). As explained in *Morahan*, para 92, the basic procedural obligation arises immediately upon death and will inform whether other procedural obligations come into play.

15. Secondly, in particular contexts, a state may be required to take the initiative to take further steps to investigate possible breaches of the substantive obligations imposed by article 2 with a view to ensuring appropriate accountability and redress and, as appropriate, with a view to punishing persons responsible for the death ("the enhanced procedural obligation"). The enhanced procedural obligation applies where there is a particularly compelling reason why the state should be required to give an account of how a person came by their death.

16. This includes cases where state agents have used lethal force (eg *McCann v United Kingdom* (1995) 21 EHRR 97); where a person has died in prison other than from natural causes, such as by reason of violence by a fellow prisoner (eg *Edwards v United Kingdom* (2002) 35 EHRR 487 - "*Edwards*"; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653 - "*Amin*"); or where a person in detention dies as a result of suicide, where there is an arguable case that this occurred as a result of a culpable failure of state authorities to protect against this possibility (*R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 - "*Middleton*"). This latter category of case has been extended to a situation where a military conscript committed suicide with a weapon supplied to him: *Kilinĉ v Turkey*, judgment of 7 June 2005, and *Ataman v Turkey*, judgment of 27 April 2006.

17. As pointed out in *Morahan*, paras 97-98, 100-104, 111-114 and 122(5)-(7), these are categories of case where the application of the enhanced procedural obligation is automatic, because of the importance attached to the need for the state in these contexts to provide full accountability in relation to the death. As Popplewell LJ explains (para 100), "[t]he procedural duty arises in the case of suspicious deaths in custody, not deaths from natural causes; and it does so automatically because all such deaths raise a sufficient possibility of state responsibility to require the enhanced investigation: suspicious deaths in custody are simply a category of case in which it is sufficiently arguable, in every case and without more, that there has been a breach by the state of one of its substantive article 2 obligations." *Morahan* itself was concerned with an inquest in respect of the death of an inpatient at a community-based open rehabilitation unit operated by an NHS trust, who left the unit with her clinicians' agreement, failed to return, and died a few days later from an overdose of recreational drugs; it was held that, in the circumstances, the enhanced procedural obligation did not apply.

18. Whether the Coroner was required to direct the jury to give an expanded form of verdict depends on whether the enhanced procedural obligation under article 2 applied in Jackie's case. Ms Richards made it clear that she did not contend that the present case is one in which an enhanced procedural obligation arose automatically. Instead, she submitted that this was a case where that procedural obligation arose because there was an arguable breach of either the systems duty or the operational duty in the particular circumstances of Jackie's case, having regard to the facts that she was deprived of her liberty, was vulnerable because of her difficulties in communicating and lack of mental capacity to make judgments about her own health, and was in the care of the state at the care home at Lytham St Anne's where she resided at the time of her death ("the care home"), which had

assumed responsibility to keep her secure and safe and to ensure she had timely access to healthcare services.

19. Thirdly, in certain other cases where a relevant compelling reason is not present as the foundation for an enhanced procedural obligation, but there is still a possibility that the substantive obligations in article 2 have been breached, there is an obligation to provide means by which a person complaining of such possible breaches may ventilate that complaint, have it investigated and obtain redress ("the redress procedural obligation"). This form of procedural obligation has typically been applied in cases involving possible breaches of article 2 in the context of provision of medical services, where it is alleged there has been negligence by medical practitioners (see *Calvelli and Ciglio v Italy,* GC, judgment of 17 January 2002 - "*Calvelli*"); it has also been applied in certain other cases where a risk to life has been said to have arisen by other forms of negligent action by state authorities (eg *Mastromatteo v Italy*, GC, judgment of 24 October 2002). As the Strasbourg Court said in the *Mastromatteo* judgment, at para 90: "The form of investigation may vary according to the circumstances. In the sphere of negligence, a civil or disciplinary remedy may suffice".

20. In accordance with this Strasbourg case-law, a substantial body of domestic case-law has held that in relation to cases of arguable medical negligence in an NHS hospital, the enhanced procedural obligation does not apply and the state's procedural obligation (in the form of the basic procedural obligation and the redress procedural obligation) is satisfied by a combination of the holding of an inquest to determine the cause of death, without any requirement of an expanded verdict, and the availability of a civil claim for damages for negligence: see eg *R (Goodson) v Bedfordshire and Luton Coroner* [2006] 1 WLR 432; *R (Takoushis) v Inner North London Coroner* [2005] EWCA Civ 1440; [2006] 1 WLR 461, paras 105-107 ("*Takoushis*"); *R (Humberstone) v Legal Services Commission* [2010] EWCA Civ 1479; [2011] 1 WLR 1460 ("*Humberstone*"), paras 55-67; *R (Parkinson) v Kent Senior Coroner* [2018] EWHC 1501 (Admin); [2018] 4 WLR 106 ("*Parkinson*"); and see the discussion in *Morahan*.

21. As was emphasised in *Humberstone*, paras 71-72, and in *Parkinson*, para 91, instances of individual negligence should not be treated as indicating a breach of the systems duty, and it will be the coroner, as the decision-maker who examines the facts in detail, hears the evidence and has to decide what form of verdict should be given at an inquest, who is best placed and has the primary responsibility to decide whether an arguable breach of either duty has been established.

22. The courts have been cautious about implying extensive positive obligations in the application of article 2 in the field of provision of medical services. *Fernandes* and *Oliveira* are the leading recent Strasbourg authorities, discussed below. However, as a further aspect of the substantive positive obligation under article 2, the Strasbourg Court has said that "an issue may arise under article 2 where it is shown that the authorities of a contracting state have put an individual's life at risk through the denial of the health care which they have undertaken to make available to the population generally": *Fernandes*, para 173; *Şentürk v Turkey* (2013) 60 EHRR 4 ("*Şentürk*"), para 88. This can be seen as a dimension of the operational duty, as it calls for positive action to be taken in the light of the specific circumstances of the individual concerned, albeit it is identified separately in *Fernandes* and the criteria for its application are stated in different terms from those which apply in relation to the more specific operational duty derived from the *Osman* judgment. It is, therefore, necessary to examine whether in the present case there was an arguable failure to comply with this aspect of the substantive positive obligations under article 2 such as would have required the Coroner to direct the jury to give an expanded verdict at the conclusion of Jackie's inquest. This aspect of the substantive obligations under article 2 is of particular relevance for the position of the care home.

23. This appeal raises issues about the boundary between the systems duty and the operational duty and the content of both of them. It also raises issues about the boundary between the enhanced procedural obligation, on the one hand, and the basic procedural obligation and the redress procedural obligation on the other.

24. In order to succeed, the appellant has to establish that at the time the Coroner made the verdict decision on 29 June 2018 the enhanced procedural obligation applied so that an expanded verdict was required in accordance with the analysis in *Middleton*. The appellant says that the enhanced procedural obligation applied in the particular circumstances of the case because Jackie was a vulnerable person who was detained and in the care of the state and there was an arguable case that there had been a breach of either the systems duty or the operational duty on the part of the care home or the various medical practitioners involved with provision of care to her, in particular on the evening of 21 February 2017.

(2) The 2009 Act and the requirement for an expanded verdict at an inquest

25. An inquest is one way in which the state may satisfy the enhanced procedural obligation under article 2: see *Morahan*, paras 68-71. According to established

interpretation of the relevant coronial legislation prior to the coming into force of the HRA, the verdict to be given at the conclusion of an inquest was confined to saying how, in the sense of "by what means", the deceased came to die: *R v HM Coroner for North Humberside and Scunthorpe, ex p Jamieson* [1995] QB 1 ("*Jamieson"*). After the coming into force of the HRA in 2000 the question arose whether the article 2 procedural obligation, when it applied in its enhanced form, required an adjustment in relation to the product of an inquest, as regards the way in which the coroner or jury expressed their conclusions. In *Middleton* it was held that it did. Lord Bingham of Cornhill explained (para 3) that there was

> "a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances in which it appears that one or other of the … substantive obligations has been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated."

26. Lord Bingham identified three questions for consideration (para 4):

> "(1) What, if anything, does the Convention require (by way of verdict, judgment, findings or recommendations) of a properly conducted official investigation into a death involving, or possibly involving, a violation of article 2?
>
> (2) Does the regime for holding inquests established by the Coroners Act 1988 and the Coroners Rules 1984, as hitherto understood and followed in England and Wales, meet those requirements of the Convention?
>
> (3) If not, can the current regime governing the conduct of inquests in England and Wales be revised so as to do so, and if so how?"

27. At the heart of the disputed factual issues in *Middleton* was the question whether the risk of suicide was properly appreciated and guarded against by the prison authorities. There was no doubt that the circumstances gave rise to the possibility that the substantive duty under article 2 to protect the

prisoner's life had been violated. Lord Bingham answered question 1 by holding (para 20) that to meet the procedural obligation “an inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case.” As to question 2, Lord Bingham concluded that there were cases in which the procedural obligation (in its enhanced form) applied where inquests as then conducted did not enable that to happen. The question now found in section 5(1) of the 2009 Act (as to how the deceased came by his death) reproduces the language of section 11(5)(b)(ii) of the Coroners Act 1988, with which *Middleton* was concerned. Lord Bingham explained that the enhanced procedural obligation might be discharged by criminal proceedings in some cases (para 30) and in others by the traditional short form verdict according to the interpretation in *Jamieson*, but the narrow *Jamieson* approach to the interpretation of the word “how” would not meet the requirements of article 2 in many cases: para 31.

28. In answer to question 3, the House of Lords decided that the change needed to satisfy the procedural obligation under article 2 was that the word “how” in section 11(5)(b)(ii) of the Coroners Act 1988 should be interpreted to mean “not simply ‘by what means’ but ‘by what means and in what circumstances’”: para 35. On the facts in *Middleton* a conclusion such as “the deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so” would meet the article 2 procedural obligation as to outcome (paras 37 and 41). Lord Bingham emphasised (also at para 37) the importance of the principle that the conclusion should not breach the statutory prohibition against appearing to determine criminal liability on the part of a named person or appearing to determine civil liability; the proposed interpretation embodied “a judgmental conclusion of a factual nature, directly relating to the circumstances of the death. It does not identify any individual nor does it address any issue of criminal or civil liability. It does not therefore infringe [the statutory prohibition].”

29. Section 5(2) of the 2009 Act included additional text to put the decision in *Middleton* on an express statutory footing. Section 10 preserved the prohibitions of the earlier statutory scheme against appearing to determine criminal liability of a named person and civil liability. It remains no part of the function of an inquest to determine civil liability, including whether there has been a breach of a substantive duty imposed by article 2, or to appear to do so.

30. Nonetheless, by reason of the interaction of the substantive obligations under article 2 and the enhanced procedural obligation, a ruling that the enhanced procedural obligation arises in a particular case may often imply a judgment

that the substantive obligations are engaged and that one or other of them has arguably been breached. Therefore, the issue in this appeal has implications beyond simply the form of the verdict which the jury was asked to give in this case. Where a public authority such as an NHS trust breaches the substantive positive obligations inherent in article 2 it may be sued for compensation for breach of its duty under the HRA to act compatibly with that Convention right: *Savage*, para 72 (Lord Rodger).

31. The question whether an enhanced procedural obligation under article 2 is engaged in a relevant way in relation to an inquest has additional consequences in practice. Where it appears that an expanded verdict may be required, because it is thought the enhanced procedural obligation is applicable, legal aid will be available to assist with the involvement of the deceased's family by the provision of legal representation. This was the issue which arose in *Humberstone*.

32. Also, a coroner will have to keep the implications of the article 2 procedural obligation in mind throughout the course of the inquest, to ensure that the examination of the circumstances of the death is sufficient to satisfy that obligation in the particular context. A coroner's assessment of this might alter during the course of an inquest, as more information comes to light as a result of his or her inquiries. The ambit of the investigation might have to be expanded, if information gathered by the coroner suggests that a simple case appearing to involve no relevant state involvement is in fact more complicated and gives rise to an arguable breach of article 2, with the consequence that the enhanced form of the procedural obligation applies and there is a requirement for an expanded form of verdict. On the other hand, information gathered before the start of an inquest (see, eg, *Morahan*, para 71) or in the course of it may eliminate areas of uncertainty and show that there is no arguable breach of article 2 such as to require an expanded form of verdict. This occurred, for example, in *Tyrrell v HM Senior Coroner County Durham and Darlington* [2016] EWHC 1892 (Admin); 153 BMLR 208 ("*Tyrrell*"), discussed below.

33. In the Coroner's assessment, that is what happened in this case. The inquest hearing commenced as a full article 2 inquest, meaning an inquest where it appeared the enhanced procedural obligation applied so that an expanded verdict would be required at the end of it in accordance with the analysis in *Middleton*. But after receiving the evidence and hearing submissions from the interested persons the Coroner's judgment in the verdict decision was that, as things had transpired, only a conventional *Jamieson*-style verdict was required or permitted.

(3) Development of the substantive positive obligations under article 2: Osman, Powell and Calvelli

34. The Strasbourg Court has examined the nature and extent of the implied substantive positive obligations under article 2 in an incremental manner. Through these cases the distinction between the systems duty and the operational duty has come to be articulated and the content of each of them has been specified more clearly.

35. The *Osman* judgment in 1998 was an influential decision at an early stage of this development. It concerned a threat to the life of a father and son posed by a third person, Mr Paget-Lewis, a teacher at the son's school, who wished them harm and succeeded in killing the father and wounding the son. The Strasbourg Court referred to both the systems duty and the operational duty at paras 115-116. At para 115 the court noted that under article 2 the state has a positive obligation "to take appropriate steps to safeguard the lives of those within its jurisdiction" which includes a primary duty to secure the right to life by putting in place effective criminal law provisions backed up by appropriate law-enforcement machinery but also extends to include "in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual." At para 116 it said:

> " … bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. Another relevant consideration is the need to ensure that the police exercise their powers to control and prevent crime in a manner which fully respects the due process and other guarantees which legitimately place restraints on the scope of their action to investigate crime and bring offenders to justice, including the guarantees contained in articles 5 [right to liberty and security of the person] and 8 [right to respect for private life] of the Convention. In the opinion of the court where there

> is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. … having regard to the nature of the right protected by article 2, a right fundamental in the scheme of the Convention, it is sufficient for an applicant to show that the authorities did not do all that could be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge. …"

On the facts of that case, no breach was established of the systems duty or the operational duty. That was so where the police had not arrested Mr Paget-Lewis and prevented his lethal attack even though he had been behaving in an increasingly bizarre and worrying way in relation to the son, including being suspected of targeting his family in the commission of acts of criminal damage.

36. In its influential admissibility decision in *Powell v United Kingdom* (2000) 30 EHRR CD362 ("*Powell*") the Strasbourg Court addressed the applicability of the *Osman* guidance in the context of a complaint brought by parents about alleged medical negligence resulting in the death of their son. It was established that he died of natural causes, the allegation being that this could have been prevented if the doctors had taken effective action at an earlier stage. The court referred, at p CD364, to *LCB*, para 36, and said:

> "The court accepts that it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of article 2. However, where a contracting state had made adequate provision for securing high professional standards among health professionals

> and the protection of the lives of patients, it cannot accept that matters such as error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a contracting state to account from the standpoint of its positive obligations under article 2 of the Convention to protect life. In the court's opinion, the events leading to the tragic death of the applicants' son and the responsibility of the health professionals involved are matters which must be addressed from the angle of the adequacy of the mechanisms in place for shedding light on the course of those events, allowing the facts of the case to be exposed to public scrutiny - not least for the benefit of the applicants."

The Court attached significance to the fact that the parents had settled their civil action in negligence against the responsible health authority and did not pursue individual claims against the doctors, regarding, at p CD365, such a civil claim as a "crucially important avenue for shedding light on the extent of the doctors' responsibility for their son's death". As a result, it was not open to the parents to complain under article 2 that there was no effective investigation into their son's death.

37. In *Calvelli* in 2002, which also involved allegations of death occurring as a consequence of medical negligence, the Grand Chamber again referred (para 48) to *LCB*, para 36. In that regard, in a reference to the systems duty, the Court said (para 49, omitting references):

> "Those principles apply in the public-health sphere too. The aforementioned positive obligations therefore require States to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives. They also require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private

> sector, can be determined and those responsible made accountable …"

The Court therefore considered (para 50) that article 2 was applicable in such a case, but had to determine what judicial response was required in the particular circumstances under the procedural obligation in article 2. It concluded that it was the redress procedural obligation which applied, not the enhanced procedural obligation: paras 51-57. The family of the deceased was able to bring civil proceedings alleging negligence (which is what they did, even though they settled the claim) and, following *Powell*, this was sufficient to lead the court to conclude that there was no violation of article 2.

38. In *Vo v France* (2004) 40 EHRR 12, at paras 88-89, the Grand Chamber repeated the analysis in *Powell* and *Calvelli*. In line with this body of authority, in *Fernandes* the Grand Chamber observed that in a case of alleged medical negligence resulting in a death, a civil action claiming compensation is "the most appropriate avenue for establishing any alleged causal link [between the alleged negligence and the death] and for shedding light on the extent of the doctors' alleged responsibility for [the] death": paras 138 and 235.

39. Case-law subsequent to *Powell* and *Calvelli* has explored the ambit of this approach to the procedural aspect of article 2. There is a tension in the Strasbourg case-law between whether the requirement to have effective means of redress available in medical negligence cases is an aspect of the substantive systems duty, as *Powell* and *Calvelli* tend to suggest (and see *Oliveira*, para 105), or is treated as an aspect of the procedural obligation under article 2. The tension was noted and discussed in *Takoushis*, at paras 84-106, and has been addressed in a number of other domestic cases, including *Amin*, *Middleton* and the cases which followed them, as reviewed in *Morahan*: see, in particular, paras 72-79, 81-82, 91-92 and 98-99. In recent Strasbourg case-law, it is said that questions of the appropriate manner required under article 2 to examine factual issues relating to alleged medical negligence are usually reviewed under its procedural limb: *Fernandes*, paras 172 and 199; *Dumpe v Latvia*, decision of 16 October 2018 ("*Dumpe*"), paras 58-59. It may be that the systems duty and the procedural obligation overlap at this point. However, for present purposes nothing turns on this and it is not necessary to give further consideration to it.

(4) Fernandes and Oliveira

40. The *Fernandes* case in 2017 concerned the death of the applicant's husband from septicaemia after a series of medical treatments in hospital in which, it

was alleged, his health problems were not properly diagnosed and addressed. It was alleged that there had been a failure of coordination between different departments in the hospital. The Fourth Section of the Strasbourg Court found that there was a violation of the substantive aspect of article 2, but there was a strong dissenting opinion to the effect that it was wrong in principle for the court to micromanage medical care and to treat alleged cases of medical negligence as involving substantive violations of article 2, so the Grand Chamber reviewed the position. It reversed the decision of the Fourth Section on this point. The Grand Chamber took the opportunity to reaffirm and clarify the scope of the substantive positive obligations of states in relation to allegations of negligence occurring in the context of provision of medical treatment by surveying a large number of authorities: paras 162-205.

41. However, at para 163 the court said:

> "The court would emphasise at the outset that different considerations arise in certain other contexts, in particular with regard to the medical treatment of persons deprived of their liberty or of particularly vulnerable persons under the care of the state, where the state has direct responsibility for the welfare of these individuals [footnote reference to *Slimani v France* (2004) 43 EHRR 49, a death in custody case, and *Centre for Legal Resources on behalf of Câmpeanu v Romania* (2014) 37 BHRC 423 ("*Centre for Legal Resources*"), paras 143-144, discussed below]. Such circumstances are not in issue in the present case."

The effect of this reservation is in question on this appeal. Ms Richards submits that it means that the judgment in *Fernandes* does not provide guidance as to the proper approach under article 2 in the present case and that the Court of Appeal erred by treating it as relevant.

42. As regards the systems duty, the court noted in *Fernandes* (para 169) that in cases concerning medical negligence it had rarely found deficiencies in the regulatory framework of states as such. At para 168 the court said (omitting footnote):

> "In cases where allegations of medical negligence were made in the context of the treatment of a patient, the court has consistently emphasised that, where a contracting state has made adequate

> provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call a contracting state to account from the standpoint of its positive obligations under article 2 of the Convention to protect life."

43. At paras 173-176 the court reviewed its case-law on denial of healthcare. In this section, at para 173, it made the observation quoted at para 22 above regarding denial to an individual of healthcare which the state has "undertaken to make available to the population generally." But the court reiterated (para 175) that issues such as the allocation of public funds in the area of healthcare are not a matter on which it should take a stand, recognising that it is for states to decide how their limited resources should be allocated.

44. At paras 177-184 the court reviewed recent developments in its jurisprudence in cases concerning a failure to provide emergency medical care in the context of natal care. It explained the finding of a violation of the substantive limb of article 2 in *Şentürk*, where the applicant's wife died in an ambulance because of the doctors' refusal to carry out an urgent operation owing to her inability to pay medical fees where they were "fully aware" that transferring her to another hospital would put her life at risk, as being based upon "a flagrant malfunctioning of the relevant hospital departments" where she "had been deprived of the possibility of access to appropriate emergency care": *Fernandes*, para 178.

45. It explained the finding of such a violation in the case of *Genç v Turkey*, judgment of 27 January 2015, [2015] ECHR 78, where the applicant's new-born baby died in an ambulance after being refused admission to a number of public hospitals owing to a lack of space or adequate equipment, as being a case where the baby had not died because there had been negligence or an error of judgment in his medical care, "but because no treatment whatsoever had been offered": *Fernandes*, para 179. It explained its decision in *Aydoğdu v Turkey*, judgment of 30 August 2016, involving the death of a premature baby, as based on a dysfunction in the health system in a particular region of Turkey,

where “the authorities responsible for health care must have been aware at the time of the events that there was a real risk to the lives of multiple patients, including the applicant’s baby, owing to a chronic state of affairs which was common knowledge, and yet had failed to take any of the steps that could reasonably have been expected of them to avert that risk”: *Fernandes*, para 181.

46. The court in *Fernandes* emphasised that in this case-law it had distinguished such cases where there was an arguable claim of a denial of immediate emergency care from cases which concern allegations of mere medical negligence: para 182. At para 200 it reiterated this point: “an alleged error in diagnosis leading to a delay in the administration of proper treatment, or an alleged delay in performing a particular medical intervention, cannot in themselves constitute a basis for considering the facts of this case on a par with those concerning denial of healthcare.”

47. The court said (para 183):

> “These cases are, in the court’s view, exceptional ones in which the fault attributable to the health care providers went beyond a mere error or medical negligence. They concerned circumstances where the medical staff, in breach of their professional obligations, failed to provide emergency medical treatment despite being fully aware that a person’s life would be put at risk if that treatment was not given [footnote reference to *Şentürk*, para 104].”

48. At para 184 the court explained that its approach in such cases was “akin to the test which it applies when examining the substantive positive obligation of the state to undertake preventive operational measures to protect an individual whose life is imminently at real risk”, as set out in *Osman*. It also emphasised that the dysfunctioning of the hospital services in *Aydoğdu* and *Genç* “did not concern negligent coordination between different hospital services or between different hospitals vis-à-vis a particular patient. It concerned a structural issue linked to the deficiencies in the regulatory framework.”

49. The Grand Chamber in *Fernandes* then authoritatively clarified the approach to be adopted at paras 186-196. It began by reaffirming (para 186) that in the context of medical negligence a state’s substantive positive obligations relating to medical treatment are limited to a duty to put in place “an effective regulatory framework compelling hospitals, whether private or

public, to adopt appropriate measures for the protection of patients' lives." Even where medical negligence is established, it will normally find a substantive violation of article 2 "only if the relevant regulatory framework failed to ensure proper protection of the patient's life"; and it reaffirmed that where the state "has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient cannot be considered sufficient of themselves to call [the state] to account from the standpoint of its positive obligations under article 2 … to protect life": para 187. A concrete examination of the facts is required to show that the relevant regulatory framework was deficient and that the deficiency operated to the patient's detriment: para 188. The state's obligation to regulate is to be understood in a broad sense, which encompasses necessary measures to ensure implementation of the regulatory framework, including supervision and enforcement: para 189.

50. In an important passage, the court continued as follows (omitting footnotes):

> "190. On the basis of this broader understanding of the states' obligation to provide a regulatory framework, the court has accepted that, in the very exceptional circumstances described below, the responsibility of the state under the substantive limb of article 2 of the Convention may be engaged in respect of the acts and omissions of health care providers.
>
> 191. The first type of exceptional circumstances concerns a specific situation where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment. It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment.
>
> 192. The second type of exceptional circumstances arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known

about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger."

The court observed (para 193) that it is not always easy to distinguish between cases involving mere medical negligence and those in the latter category where there is a denial of access to life-saving emergency treatment, but it emphasised (paras 194-196) that to fall into that category three conditions have to be met. These are that the acts and omissions of the healthcare providers must go beyond a mere error or medical negligence, in that they, in breach of their professional obligations, deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given (para 194); the dysfunction at issue must be genuinely identifiable as systemic, and "not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly" (para 195); and there must be a causative connection between the state's systems obligation, the dysfunction complained of and the harm suffered by the patient (para 196).

51. The Grand Chamber concluded that there had been no violation of the substantive limb of article 2. It had not been demonstrated that the alleged fault attributable to the healthcare professionals went beyond a mere error or medical negligence or that they "failed, in breach of their professional obligations, to provide emergency medical treatment to [the deceased] despite being fully aware that his life was at risk if that treatment was not given"; and the alleged lack of coordination between hospital departments did not amount to a dysfunction in hospital services capable of engaging the state's responsibility under article 2: para 202. The case concerned allegations of medical negligence, in relation to which the state's substantive positive obligations were limited to compliance with the systems duty, and the relevant regulatory framework did not disclose any shortcomings: paras 203-204. There had, however, been a violation of the redress procedural obligation under article 2 in the circumstances of the case, because of excessive delay in the determination of civil proceedings brought by the applicant alleging negligence on the part of the health professionals: paras 235-238.

52. In *Oliveira* in 2019 the applicant's son suffered from severe mental health problems. He committed suicide while a voluntary inpatient at a psychiatric hospital. He was originally placed under a restrictive regime, but in light of an improvement in his condition this was lifted and he was given more freedom

to move about within the hospital grounds. However, he left the grounds and jumped in front of a train. The applicant brought a civil claim against the hospital alleging that the suicide had been caused by the lack of appropriate containment and supervision of her son, including the lack of fencing around the hospital grounds, the lack of a mechanism to check the presence of inpatients so that staff would immediately be alerted in the case of absence, and the lack of an emergency procedure capable of detecting an inpatient's absence which would have allowed the hospital staff to adopt effective measures to safeguard her son's life and the lives of others. After eight years, the civil claim against the hospital was determined and dismissed at first instance. The applicant's appeal was dismissed after a further period of three years. The Grand Chamber, reversing the judgment of the Chamber, held that there had been no violation of the substantive limb of article 2. But it found (paras 138-140) that there had been a violation of the procedural limb of article 2 due to the long delay in the determination of the applicant's civil claim.

53. The court in *Oliveira* referred to *Fernandes* as an authority which provided relevant guidance and addressed the application based on the substantive limb of article 2 in relation to the systems duty (*Oliveira*, paras 105-107 and 116-123) and the operational duty (*Oliveira*, paras 108-115 and 124-130).

54. As regards the latter, the court referred to the guidance in para 116 of the *Osman* judgment (see para 35 above) and reiterated (para 112) that "the very essence of the Convention is respect for human dignity and human freedom", referring in that regard in particular to the Convention rights in article 3 (prohibition of inhuman or degrading treatment), article 5 (right to liberty and security of the person) and article 8 (right to respect for private life), meaning that the authorities had to discharge their duties "in a manner compatible with the rights and freedoms of the individual concerned and in such a way as to diminish the opportunities for self-harm, without infringing personal autonomy". The court referred (para 113) to the particular vulnerability of mentally ill persons, so that "[w]here the authorities decide to place and keep in detention a person suffering from a mental illness, they should demonstrate special care in guaranteeing such conditions as correspond to the person's special needs resulting from his or her disability. The same applies to persons who are placed involuntarily in psychiatric institutions." At para 115, the court referred to a range of factors concerning suicide risks where a person is detained by the authorities which are relevant to the question whether the authorities knew or ought to have known that the life of a particular individual was subject to a real and immediate risk such as to trigger the operational duty.

55. The court dismissed each aspect of the applicant's case based on breach of the systems duty. As regards her complaint about the lack of a security fence around the hospital grounds, the court emphasised that this reflected the legitimate therapeutic desire to create an open regime where the patient retained the right to move about freely; and the regulatory framework permitted the imposition of a more restrictive framework when it was assessed to be necessary: para 117. Written guidelines in respect of restraint measures applicable to psychiatric patients had not been in place at the time of the death (meaning that the issue of restraint was left to the professional judgment of those dealing with the deceased at that time), but the court did not see this "as a deficiency which would in itself render the regulatory framework ineffective for the purpose of providing the necessary means for the protection of [the deceased's] life": para 118. The purpose of the regulatory framework requirement under article 2 is to provide the necessary tools for the protection of a patient's life, and "the lack of a written policy on the use of restraint measures is not determinative of its efficiency" and did not warrant a finding that article 2 was breached: para 119.

56. The court also dismissed the complaint regarding the surveillance procedure for checking on voluntary inpatients only at meal and medication times. It noted that a more restrictive surveillance procedure was also available when considered necessary by the treating doctor, as well as other forms of restraint when considered necessary, so the regulatory framework provided the hospital with the tools necessary for the treatment of the deceased (even though they were not in fact utilised at the time of his death): para 120. The court also accepted the finding of the domestic court that the surveillance procedure in place was intended to respect the privacy of the deceased and was in line with the principle of treating patients under the least restrictive regime possible, noting that use of excessively restrictive measures might give rise to issues under articles 3, 5 and 8 of the Convention: para 121. The court considered that the emergency procedure when an absence was noted, consisting of alerting the doctor on call, the police and the patient's family, was adequate: para 122.

57. As regards the operational duty, the court explained the position at para 124 of *Oliveira*. It observed that a person with severe mental health problems, including a psychiatric patient being treated on a voluntary basis, is in a vulnerable position, as their capacity to take a rational decision to end their life may be impaired and "any hospitalisation of a psychiatric patient, whether involuntary or voluntary, inevitably involves a certain level of restraint as a result of the patient's medical condition and the ensuing treatment by medical professionals", since recourse to further kinds of restraint in the process of treatment is often an option, limiting liberty and privacy rights. It continued:

> "Taking all of these factors into account, and given the nature and development of the case-law referred to [at paras 108-115 of the judgment], the court considers that the authorities do have a general operational duty with respect to a voluntary psychiatric patient to take reasonable measures to protect him or her from a real and immediate risk of suicide. The specific measures required will depend on the particular circumstances of the case, and those specific circumstances will often differ depending on whether the patient is voluntarily or involuntarily hospitalised. Therefore, this duty, namely to take reasonable measures to prevent a person from self-harm, exists with respect to both categories of patient. However, the court considers that in the case of patients who are hospitalised following a judicial order, and therefore involuntarily, the court, in its own assessment, may apply a stricter standard of scrutiny."

I think it may be inferred that a stricter standard of scrutiny will be applied because the very fact that a judicial order has required hospitalisation shows that the risk of doing harm to oneself or to others has been highlighted to such a degree as to warrant detention to contain it.

58. The court bore in mind the operational choices which must be made in terms of priorities and resources in providing public healthcare and other public services in the same way as it takes into account the difficulties involved in policing as highlighted in *Osman*: *Oliveira*, paras 125 and 131. The restrictive regime was lifted when it was considered the deceased's symptoms showed improvement, which was in line with the hospital's philosophy of giving patients a considerable degree of freedom of movement in order to increase their sense of responsibility and promote their reintegration into family and society, and the court saw no reason to question the assessment of his treating psychiatric doctor that his treatment, involving taking his prescribed medication, receiving the treatment voluntarily and establishing a relationship of trust was appropriate and proportionate in the circumstances: para 130. While the applicant's son was at risk of suicide, in the circumstances it had not been established that the authorities knew or ought to have known that there was an immediate risk to his life so as to require consideration of the protective measures taken: paras 131-132.

59. A theme which emerges in the *Oliveira* judgment is that in assessing the application of the operational duty as an aspect of the implied substantive obligation under article 2 it is relevant to take into account the wider interests of the vulnerable person who is said to be at risk, in terms of promoting their autonomy, integration into society and relationships of trust with those caring for them: paras 112-113, 121-122, 125 and 130-132.

60. This has also been recognised at the highest level in the domestic jurisprudence. As Lord Dyson had observed in the leading judgment in *Rabone* in 2012, before *Fernandes* and *Oliveira* were decided, at para 43: "The standard demanded for the performance of the operational duty is one of reasonableness. This brings in 'consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available': per Lord Carswell in *In re Officer L* [2007] 1 WLR 2135, para 21. In this case [*Rabone*], it also required a consideration of respect for the personal autonomy of Melanie [the voluntary inpatient who committed suicide]". Baroness Hale made the same point in *Rabone*, para 107: "There is a difficult balance to be struck between the right of the individual patient to freedom and self-determination and her right to be prevented from taking her own life" (see also para 104).

61. In *Parkinson*, after a review of Strasbourg and domestic case-law up to and including *Fernandes*, the Divisional Court (Singh LJ, Foskett J and HHJ Lucraft QC) said (para 86) that the enhanced procedural obligation "will only arise in medical cases in limited circumstances, where there is an arguable breach of the state's own substantive obligations under article 2", and went on to observe (para 87) that "matters such as an error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call the state to account under article 2."

62. In my view, the first of these statements is correct as a general proposition as regards the systems duty and the operational duty: see *Morahan*, paras 75 and 78-79, 83-86, 98-100 and 122(4) (reviewing the effect of *Middleton*, *R (L (A Patient)) v Secretary of State for Justice* [2009] AC 588; *R (Gentle) v Prime Minister* [2008] AC 1356; and *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1). However, the second statement is not accurate: in such cases, the basic procedural obligation is likely to apply and there may be an issue regarding the protection of life under article 2 requiring the state to be called to account, but the procedural obligation in such circumstances is limited so that this requirement is satisfied by provision of the possibility of a civil action for negligence. As regards the statement at para 86 in *Parkinson*, it is clear that what will qualify as an arguable breach of the systems duty or the

operational duty such as to trigger the enhanced procedural obligation calls for examination of their substantive content: see below.

(5) The facts

63. Jackie was born on 28 April 1964. She had Down's Syndrome, in addition to learning disabilities and behavioural difficulties and certain physical limitations. She lived at home between 1982 and 1991 but then exhibited bouts of extreme behaviour, diagnosed as cyclothymic personality disorder.

64. After a placement at an assessment centre, from 1993 Jackie lived in the care home, managed by United Response, which provided private residential care. The care home was registered with the relevant regulator, the Care Quality Commission ("CQC"), and was subject to periodic inspections. It provided accommodation for adults with learning difficulties who required round-the-clock supervision and assistance with personal care. At the material time it had five residents. It was not a nursing home. Its staff had neither medical nor nursing training.

65. Jackie's placement at the care home was paid for and supervised by Blackpool City Council ("the Council"), in the discharge of their statutory functions to provide support for an adult with her combination of difficulties. For her own safety and care, Jackie was not permitted to leave the care home without supervision. The doors were kept locked. As explained by this court in *Cheshire West and Chester Council v P* [2014] UKSC 19; [2014] AC 896, with reference to *HL v United Kingdom* (2004) 40 EHRR 761, to be kept in such circumstances constitutes a deprivation of liberty for the purposes of article 5 of the Convention. Jackie was, therefore, subject to a standard authorisation for such interference with her liberty in her best interests granted by the Council pursuant to the Deprivation of Liberty Safeguards ("DoLS") set out in Schedule A1 to the Mental Capacity Act 2005 ("the MCA 2005").

66. Jackie could communicate. However, a capacity assessment carried out by a psychiatrist, Dr Ali, in March 2016 concluded that Jackie lacked capacity for the purposes of the MCA 2005 in various respects. Dr Ali found that Jackie was a vulnerable adult with no insight and was totally dependent on staff at the care home for her day-to-day care. In his view, she fell to be considered for deprivation of liberty, subject to the DoLS, in her own best interests. A social worker, Mr Fryar, also made a best interests assessment for Jackie to support the standard authorisation pursuant to the DoLS in which he noted her dependence on others and that the staff at the care home made sure that she had appropriate and timely access to her GP and other NHS services.

67. In recent years, spinal problems had restricted Jackie's mobility to the extent that she used a wheelchair for trips outside the care home. She took anti-inflammatory medication to manage back pain and medication to manage the risk of gastric ulceration from anti-inflammatories.

68. Jackie was fearful of medical interventions and sought to avoid them. She had refused a blood test in 2013 and accordingly her medical records noted that she would require diazepam (a sedative) and a home visit if an injection were ever required. In November 2016 Jackie refused to agree to her GP taking blood for a test as part of an investigation into stomach pain she was experiencing. In December 2016 she attended hospital for an ultrasound scan as part of that investigation, but this was not completed due to her becoming upset during the scan. Jackie continued to complain of stomach pain periodically until the time of her death.

69. From 16 February 2017 it was noted that she was not eating well and was complaining of a sore throat. She suffered from diarrhoea.

70. On 20 February 2017 Jackie vomited and had a raised temperature. She asked to see a GP, but this request was not acted on.

71. On 21 February 2017 one of the support workers at the care home, Susan Egan, noted that Jackie was experiencing breathing difficulties. Later that morning, Jackie asked to see a doctor. Ms Egan did not act immediately on that request, but at 2.55 pm she telephoned Jackie's GP practice and requested that a GP visit her, as she had suffered a "possible collapsing episode at 2.15 pm" and had refused food and drink. The GP's receptionist told Ms Egan that the request for a visit would be considered later that day. At 3.20 pm Ms Egan telephoned again to report further symptoms.

72. At 3.36 pm Ms Egan telephoned the NHS 111 service for the North West of England ("NHS 111"), an out-of-hours medical advice service run by the North West Ambulance Service ("NWAS"). She informed the call handler that Jackie had been vomiting, and described her vomit as being like coffee; she was complaining of terrific pains in her stomach; she had had a fit; and she had been saying earlier that she did not feel well and wanted a doctor. When asked if Jackie had any physical or sensory disabilities, Ms Egan responded "No". NHS 111 advised Ms Egan to telephone Jackie's GP, and Ms Egan explained she had done that already. NHS 111 said that she should try again with a request for a home visit within two hours.

73. At 4.59 pm Jackie's GP, Dr Sarfraz Adam, telephoned the care home and spoke to another carer (Chloe Le Saint) about Jackie's condition. He advised that she was suffering from viral gastroenteritis and a urinary tract infection. He did

not think it was necessary to make a home visit to see her, but prescribed anti-sickness medication and an antibiotic. (At the inquest, Dr Adam accepted that, with the benefit of hindsight, the information he was given when he called warranted a home visit and that he should have gone to see Jackie).

74. At about 7 pm Jackie asked to go to bed. She walked to the bottom of the stairs and collapsed. Ms Le Saint was unsure whether she had fainted or had a fit. Two members of staff helped Jackie to the bathroom where she collapsed again. She was taken to bed. At 7.14 pm Ms Le Saint telephoned NHS 111 to request an ambulance. In response to questions Ms Le Saint informed the call handler that Jackie was warm to touch; she had had a crushing pain in her chest/upper abdomen in the last 24 hours; she had been in pain in the last 12 hours and had been vomiting what looked like coffee grounds (the medical significance of this is that coffee ground vomit is generally interpreted as a sign of haematemesis, ie vomiting blood); there had been blood in the toilet when Jackie last visited; she had collapsed three times that day; she would not sit still; she got scared and would need to be sedated to be seen.

75. NHS 111 arranged for an emergency ambulance to be sent, but owing to administrative error the ambulance crew were not informed that Jackie had Down's Syndrome and learning disabilities, nor informed about many significant details of her symptoms.

76. The ambulance arrived at 8.03 pm. Its crew consisted of paramedic Hannah Ayres and emergency technician Graham Peters (together, "the paramedics"). They spoke to Ms Le Saint. There was a degree of conflict and confusion at the inquest regarding what exactly they were told, but the basic picture emerges from the evidence of Ms Ayres. She stated that she was told by Ms Le Saint that Jackie had had a vacant seizure at the bottom of the stairs at about 3 pm that day and was staring blankly for about two minutes; she had had loose bowels for about one and a half weeks and vomiting for two days. Ms Ayres said that she was not informed by NHS 111 or Ms Le Saint of Jackie's seizure at about 7 pm.

77. The paramedics carried out their own observations and considered what should be done. They checked Jackie's heart rate (which at 100 was raised), her blood pressure (which at 93/58 was low) and its oxygen saturation (which at 92% was low). Her temperature was normal. Her chest rattled.

78. The paramedics wanted to take Jackie to hospital for assessment, due to the unusual vacant seizure. The care home staff agreed. Jackie's mother, Mrs Maguire, was spoken to on the telephone and she also agreed. However, Jackie refused to go to hospital. The paramedics and the care home staff tried to persuade her, but without success.

79. The paramedics were concerned that Jackie did not have capacity to weigh up for herself the consequences of not attending hospital. However, in order to make her go to hospital she would have to be restrained and manhandled; the paramedics were not qualified to administer sedation, which would have required a medical assessment. The paramedics thought that if they used force the likelihood of causing injury or harm was very high and was disproportionate to the state she was in at the time. Jackie seemed fine in herself. She was alert, was not complaining of any pain, and at that time was showing no signs of discomfort. She was speaking and was not subject to cyanosis (blue skin or lips due to insufficient oxygen in the blood or poor circulation). In the paramedics' assessment, Jackie was not displaying any red flag signs which would have indicated that her life was at risk.

80. At 8.35 pm Ms Ayres sought advice from Dr Susan Fairhead, an out-of-hours GP. According to Dr Fairhead's evidence at the inquest, she was told that Jackie had had diarrhoea for a week and had started vomiting a couple of days previously; she had suffered a small seizure at about 2.15 pm when her eyes had rolled back in her head; she was refusing to leave her bedroom despite being advised that it was better for her to go to hospital; she had had no further episodes of vomiting or further faints and following the original episode she had recovered quickly. Dr Fairhead advised that, since Jackie was stable, while they should try to convince her to go to hospital it would be inappropriate to manhandle her; she should be monitored during the night and her GP should be called in the morning. (When questioned at the inquest Dr Fairhead accepted that her triage was poor; she should have asked the paramedics for detailed observations and, had she done so, it was likely this would have led her to advise an immediate admission to hospital; if Jackie had refused to go, Dr Fairhead said that she would have sent the visiting GP who would have carried sedatives and would have had the ability to sedate Jackie if necessary, to assist in effecting a transfer to hospital).

81. Mrs Maguire telephoned the care home several times during the evening and spoke to a member of staff, Sherrill Clayton. Mrs Maguire suggested that a sedative could be used to assist with a transfer to hospital. It was unclear on the evidence given at the inquest whether this suggestion was passed on to the paramedics, but in any event they were not themselves qualified to administer a sedative and Dr Fairhead was in a position to advise about this, if she had thought it was appropriate.

82. The paramedics' assessment was that the situation did not warrant restraining Jackie and manhandling her to get her to hospital. The best course was for Jackie to remain at the care home with someone checking on her during the night. This task was undertaken by Ms Le Saint. There is some controversy about whether this was done, and with what frequency.

83. By the morning of 22 February 2017 Jackie was acutely unwell. At 6.30 am Ms Le Saint found Jackie and her bedclothes soiled with faeces. She was reluctant to get out of bed. When she did so about 45 minutes later, she collapsed. Ms Egan arrived for work about 30 minutes later and helped Ms Le Saint to move Jackie to the bathroom where she collapsed once more and appeared to suffer a seizure. At this time, the care home manager, Sharon Simpson, arrived at the care home. On seeing Jackie unconscious on the bathroom floor, at 8.12 am she telephoned the emergency 999 service to call an ambulance.

84. Another ambulance crew arrived at 8.21 am. They were advised of Jackie's recent history, including her episode of haematemesis. Jackie was now extremely unwell but still resisted attempts to convey her to the ambulance. Having concluded that she lacked capacity to make decisions regarding her treatment, the ambulance crew decided that it was in her best interests to use light physical restraint to take her to hospital. Jackie was secured to a carry-chair by her legs and was carried to the ambulance.

85. Jackie arrived at Blackpool Victoria Teaching Hospital, run by an NHS trust ("the Hospital Trust") at 9.22 am. On admission she was treated with antibiotics and fluid resuscitation for presumed sepsis. Tragically, Jackie died at about 7.40 pm on 22 February 2017 following a cardiac arrest. Amongst their many concerns about Jackie's treatment, her family also have concerns about the care provided to her at the hospital.

86. A post-mortem was carried out on 28 February 2017. This recorded a 3 cm stomach ulcer which had perforated Jackie's stomach and resulted in peritonitis. According to evidence at the inquest, it is likely that this had developed over several months.

87. At the inquest, independent expert witnesses instructed by the Coroner gave evidence. The principal independent expert witness was Dr Peter Goode, a consultant with expertise in emergency medicine. He expressed the view that Jackie was on a sepsis pathway on 21 February 2017, at which time the risk of death was 30-40%. This was not identified by either Dr Adams or Dr Fairhead, nor by the paramedics who attended at the care home that day. By the morning of 22 February when she was admitted to hospital, Dr Goode assessed that the risk of death had increased to 70%.

88. At first instance, the Divisional Court (Irwin LJ, Farbey J and HHJ Lucraft QC) recorded that the significant facts were not in dispute: [2019] EWHC 1232 (Admin), para 9.

89. The Coroner opened an inquest into Jackie's death on 3 August 2017. The substantive inquest with a jury took place between 20 and 29 June 2018, with final submissions on 2 July. Around 30 witnesses were called to give evidence. The investigation undertaken by the Coroner into the circumstances of Jackie's death was thorough. Apart from in relation to the verdict, it is accepted that it was fully compliant with the requirements which article 2 imposes. Jackie's family had the opportunity to participate in the inquest, were represented by counsel (Ms Formby) and had full access to the evidence. The issue in the appeal is concerned only with the form of the verdict which was required to be given.

90. For the purposes of the inquest, in the period from March 2017 detailed witness statements were taken from the staff at the care home, senior managers at United Response, the paramedics, the GPs and other doctors involved with Jackie's care on 21-22 February 2017 and her post-mortem, the Medical Director responsible for the NHS 111 service (Dr Katherine Noble) and the Quality Assurance Lead for the relevant Emergency Operations Centre for NWAS (Mr Nikky McCormack-Gray). Dr Goode and other independent experts compiled detailed reports.

91. Prior to the commencement of the inquest, a series of other investigatory steps were taken. These were not the subject of detailed evidence in these proceedings, but were described in evidence given at the inquest. In broad outline, they were as follows.

92. United Response conducted its own review of what had happened, with a view to learning lessons. Staff at the home had made daily records of Jackie's condition. The outcome of the review was a renewed focus on training for staff at the care home, including to make sure everything was recorded, streamlining of documentation and changes in the out-of-hours duty management system.

93. The CQC conducted its own investigation into United Response, having regard to the circumstances of Jackie's death. It did not find any lapse in the standard of care to be expected of the care home and its staff.

94. Advanced Paramedic Vincent Romano of NWAS conducted a review of the actions of the paramedics on 21 February 2017, which concluded that they had acted appropriately in assessing Jackie, including obtaining advice from the out-of-hours GP, and had acted in the best interests of Jackie with the information available to them when deciding that she should not be restrained and moved to hospital. Mr Romano also attended the inquest and gave evidence to explain his report and his conclusions. He confirmed that in his opinion the decision taken by the paramedics was appropriate in the

circumstances. Sedation was not within the scope of training of a paramedic; it would not be for them to suggest it, but would be a decision for a trained clinician. In his view, sedation would not have been appropriate on the evening of 21 February 2017 because, like physical restraint, it would create risk for the wellbeing of the patient which would not have been justified according to the symptoms Jackie was displaying at the time. According to Jackie's presentation at the time of the paramedics' visit, she was not displaying symptoms of such great severity or such pressing concern that it would have been reasonable to use force to remove her to hospital at that stage for checks. In Mr Romano's view, there was nothing else that the paramedics could have done to get Jackie to hospital in a safe manner.

95. In his witness statement, Mr McCormack-Gray explained that he had reviewed the operation of the NHS 111 Service in relaying information to the ambulance service on the evening of 21 February 2017. Usually, information is relayed by means of electronic transfer, which gives the ambulance crew access to the information provided by the person calling the 111 number. Occasionally, as happened in this case, the electronic transfer system fails, in which case the back-up procedure is for the ambulance service dispatcher who is called by the nurse from the NHS 111 Service to note the details provided and enter them manually into the emergency dispatch system for the ambulance crew. Mr McCormack-Gray identified that some information provided by the person calling the 111 number was not correctly recorded by the dispatcher and so was not passed on to the ambulance crew. The information that Jackie had Down's Syndrome, learning difficulties and poor vision was not passed on. No information relating to the immediate cause for an ambulance to be deployed was passed on other than that Jackie had fainted. Dr Noble also identified failures within the NHS 111 Service in relation to the handling of calls from the care home about Jackie and in respect of passing on information provided by the care home as appropriate. In response to questions posed by the Coroner, Dr Noble explained what lessons had been learned and what steps had been taken to improve performance.

96. The inquest was formally opened on 3 August 2017. Thereafter, two pre-inquest review hearings were held at which various procedural matters were addressed. In this period, on 19 December 2017, the *Fernandes* judgment was promulgated.

97. The first pre-inquest review hearing was on 8 September 2017. Having reviewed the available material and heard submissions from the interested persons, including Mr Kenneth Maguire on behalf of Jackie's family, the Coroner held that (with particular reference to the test in *Osman*) article 2 was not engaged and there was no arguable breach of its substantive aspect. He therefore proposed to conduct the inquest as a *Jamieson*-style inquest

rather than as a *Middleton*-style inquest (with an expanded form of verdict); but he noted that this was a matter which would be kept under review in light of the evidence heard during the course of the inquest. In the exercise of his discretion under section 7 of the 2009 Act, having regard to the facts that Jackie was a vulnerable person with Down's Syndrome and was the subject of a DoLS order, the Coroner directed that the inquest should take place with a jury.

98. A second pre-inquest review took place on 18 December 2017. Jackie's family and other interested persons, including Dr Adam, Dr Fairhead, United Response and NWAS, were represented by counsel. The Coroner's provisional view was that there was no arguable breach of article 2 in relation to the healthcare provision for Jackie on 21-22 February 2017 and the fact that she was subject to deprivation of liberty pursuant to a DoLS authorisation did not serve to change this position. Ms Kohn, then representing Jackie's family, pointed out that the Grand Chamber judgment in *Fernandes* was about to be handed down and submitted that there had, at least arguably, been a breach of the substantive aspect of article 2 so as to require a *Middleton*-style verdict. The Coroner reserved his decision in order to be able to review the judgment in *Fernandes*.

99. By a determination promulgated on 9 February 2018 the Coroner decided that article 2 was not automatically engaged (meaning, on the basis that Jackie had died while in custody), but was engaged on the grounds that there had been an arguable breach of article 2 on the part of the care home, the ambulance service, the GPs or the Hospital Trust (or a combination of them) in terms of affording Jackie access to the treatment she needed, particularly in the light of *Rabone*. The Coroner indicated that, given Jackie's death as a result of a stomach ulcer, the inquest would need to consider how it had developed, how her symptoms were communicated, and what efforts were made to provide her with medical attention bearing in mind it had been reported that she had not attended two previous medical appointments; the circumstances in which her GP (Dr Adam) did not attend to examine her and whether this was in accordance with relevant guidelines; whether the ambulance crew attending on 21 February 2017 ought to have done more to make Jackie go to hospital; whether the care home staff understood the powers available to effect Jackie's attendance at hospital with the ambulance crew, and whether the care home had a care plan which advised staff what action was required in the event of a medical emergency involving someone subject to a DoLS authorisation and how this affected communication between the care home staff and the ambulance crew; and whether the care provided by the Hospital Trust was provided in a timely fashion, and if not whether this contributed to Jackie's death and whether issues connected with her reported learning difficulties affected this.

100. On 15 June 2018, shortly before the inquest began on 20 June 2018, the judgment of the Divisional Court in *Parkinson* was handed down. It was drawn to the attention of the Coroner on the first day of the substantive inquest hearing.

101. In the course of the inquest, the Coroner received evidence about the systems in place in and in relation to the care home, NWAS and the Hospital Trust. So far as concerned the care home, the evidence was that there was a system in place for communication between staff covering different shifts at the care home and between the care home staff and healthcare professionals: (i) a communications book, in which staff were required to record all healthcare and other appointments for each resident and details of any contact made with the care home by third parties, including family members; (ii) daily recording charts which staff were required to complete during and at the end of each shift setting out all relevant information about the care provided to each resident, any concerns about the resident's health or welfare and any significant events which occurred during the shift; (iii) a system of oral handovers between staff at the end of each shift, including provision of information regarding any concerns about the resident's health or welfare and any significant events that occurred during the shift; and (iv) medical appointment forms which staff were required to complete after a resident had any contact with healthcare professionals, setting out the reasons for the contact, the diagnosis, any medicines prescribed and any other relevant information. Evidence was also given regarding the training of care home staff.

102. The Coroner also received evidence about the systems and training in place within the various aspects of the healthcare services engaged in relation to Jackie's treatment.

103. Dr Goode addressed the position of the paramedics attending on 21 February 2017 in his report (paras 9.11-9.13), in which he gave his opinion that use of force to take Jackie to hospital would have been justified. However, he expanded on this in his oral evidence at the inquest. In relation to the decision of the paramedics not to use force to compel Jackie to go to hospital, Dr Goode explained that this was a "grey area" and said, "[t]here is not an easy answer to this. I would suspect that if the paramedic crew at the time had been more forceful they may well have been criticised for that". He considered that the decision not to compel Jackie to go to hospital, but to leave her at the care home subject to being checked by staff, was within the range of reasonable options open to the paramedics. He also gave evidence that use of sedation in such circumstances would be very rare.

104. Dr Goode's evidence at the inquest, by reference to the transition to the transcript of the relevant recordings, was that the staff at the care home provided full answers to the questions posed to them about Jackie's symptoms when they called the NHS 111 service and when seeking advice in the afternoon of 21 February 2017, and had again passed on all the salient signs and symptoms when calling for an ambulance that evening.

105. Dr Goode did not suggest that there was anything defective in the care home's systems for recording information about events affecting residents at the care home; nor did he suggest that the care home should have had in place a protocol regarding the transfer of Jackie, or any resident with impaired capacity, to hospital in the event that he or she was resistant; nor did he suggest that the paramedics should have been trained in the use of sedation or have had in place any specific training or procedures other than those in place at the time. This is particularly telling, since Kenneth Maguire had written posing questions about these matters and Dr Goode set these out in his report.

106. In Dr Goode's written report (paras 9.13-9.15) he noted that the paramedics had called the out-of-hours GP (Dr Fairhead) and he raised a concern about whether an out-of-hours doctor might have attended to "perhaps use medication to reduce [Jackie's] anxiety and allow her to be safely moved to hospital"; he pointed out that the actions of Dr Fairhead would require comment from an expert GP with out-of-hours experience (for this reason the Coroner instructed Dr Napier as such an expert to provide that comment); but he did not criticise the paramedics for their actions or in respect of the procedures they had in place.

107. Counsel for Jackie's family at the inquest did not challenge the evidence of Dr Goode or Mr Romano in relation to the matters referred to above. It was not suggested to them that the procedures at the care home or within the NWAS or that the actions taken by care home staff or by the paramedics were inappropriate or deficient.

108. At the close of evidence, on 28 June 2018 the Coroner invited further submissions regarding the engagement of article 2 in the circumstances of the case, in the light of the evidence received, and as to the form of verdict which the jury should be instructed to give. On 29 June 2018 he gave his ruling in the verdict decision, which is the subject of challenge in these proceedings. He revisited his previous ruling that the enhanced article 2 procedural obligation was engaged in this case and concluded that matters had now been clarified to such a degree that article 2 was no longer engaged in any relevant way.

109. The Coroner reminded himself of the test in *Osman*. His assessment was that Jackie's death related to the provision of healthcare to her, so that the guidance given in *Parkinson*, at paras 82-91, was relevant. Ms Formby, for Jackie's family, maintained there had been systemic failures, but she did not contend that there had been a breach of the *Osman* operational duty by anyone. She focused, first, on the failure of the paramedics to transfer Jackie to hospital on 21 February 2017 and the absence of a system to make sure that they did and, secondly, on issues in relation to record-keeping at the care home. (By contrast with the way the case was argued before this court, it should be observed that Ms Formby did not contend that there was a systems failure consisting in either the care home or the ambulance service not having in place a protocol to state that if Jackie needed to be taken to hospital but was resistant, she should be sedated).

110. Counsel for the other interested persons made opposing submissions dealing with both points. It was submitted that the paramedics operated under a system framed by the MCA 2005 according to which they had to make a best interests assessment in relation to Jackie in the situation with which they were confronted and where, when in doubt, there was a system under which they could seek advice from a trained medical practitioner, as in fact they did. The care home had systems in place for the recording and sharing of significant information about residents and their well-being, and according to which advice would be sought from trained medical practitioners when medical problems arose and, if need be, an ambulance would be called; and the staff at the care home sought access to trained medical practitioners on behalf of Jackie as the system in place provided for, by contacting Dr Adam, the NHS 111 service and Dr Fairhead and by calling an ambulance on 21 February 2017.

111. For the purpose of deciding the form of verdict which the jury should be asked to give, the Coroner found that there was no failure by United Response to have in place appropriate systems at the care home and no failure by the ambulance service to have appropriate systems in place. He was dealing with a case concerning a death associated with medical treatment, as in *Parkinson*, with the result that the article 2 investigative obligation (by which he meant the enhanced procedural obligation) was not engaged if what was being alleged amounted to no more than medical negligence by healthcare staff; and in his assessment that was the position with which he was concerned. In his view it could not be said that Jackie's life had knowingly been put in danger by the denial of access to life-saving emergency treatment. The Coroner also addressed a submission whether a finding of neglect should be left to the jury, in the light of *Jamieson*. He considered that Jackie had been in a dependent position and required basic medical attention, but there were no failings by any individual that could arguably be regarded as instances of

gross neglect which ought to be placed before the jury for consideration as such; nor was there a proper case to go to the jury of gross neglect on a cumulative basis.

112. Therefore, the Coroner decided that the enhanced procedural obligation under article 2 did not apply in the circumstances of the case, with the result that section 5 of the 2009 Act did not require or permit a direction to the jury to give an expanded verdict. Accordingly, he directed the jury to give a short *Jamieson*-style verdict. The verdict they returned recorded that Jackie had died of natural causes.

113. At the close of the inquest the Coroner completed a form recording matters of concern which had arisen in respect of Jackie's death. He identified only one, which related to the approach of out-of-hours GPs in cases of this kind. Dr Fairhead had not been sufficiently probing in her triage discussion with Ms Ayres before giving her medical advice to leave Jackie at the care home overnight on 21 February 2017.

114. The Coroner's concern was that such GPs might be asked to provide medical advice at a time when it could be compromised because the medically untrained member of staff calling them and trying to explain the patient's presentation and symptoms is unable to do so effectively. Interaction with a patient with learning difficulty and limited communication abilities could leave the staff member with an incomplete or incorrect view about the patient's condition, so that the GP is not equipped with the whole picture. If possible, therefore, it would be better for the GP to attend to assess the patient "one to one". The Coroner recorded no concerns about the training, systems and procedures in place within the care home, the Hospital Trust, the NHS 111 service or in relation to the paramedics.

(6) The judicial review proceedings in the Divisional Court and the Court of Appeal

115. Mrs Maguire issued these judicial review proceedings on 26 September 2018. At that stage counsel acting for Mrs Maguire were Ms Victoria Butler-Cole KC and Ms Nicola Kohn. The principal relief claimed was a declaration that the circumstances of Jackie's death "engaged" article 2, contrary to the verdict decision of the Coroner on 29 June 2018; a declaration that the Coroner erred in law in withholding the issue of neglect from the jury; and an order requiring a new inquest to be held.

116. In these proceedings, the Coroner has adopted a neutral position throughout in line with the suggestion by Brooke LJ in *R (Davies) v*

Birmingham Coroner [2004] 1 WLR 2739, paras 47 and 49. At first instance and in the Court of Appeal, the main submissions in opposition to the application for judicial review were presented by counsel for United Response. In the Supreme Court, however, United Response did not appear by counsel to make submissions, nor did any other respondent apart from the Coroner make submissions. Therefore, at this level the Coroner's continued neutral stance has posed problems.

117. Although Mr Beer, for the Coroner, made a contribution by way of submissions about the general legal framework in which inquests take place, the court did not have assistance by way of full argument to understand the detailed factual circumstances of the case and how they might bear upon the issues in the appeal: such argument need not have been inappropriately adversarial. The agreed statement of facts and issues did not clarify matters as it should have done. In future, I would suggest that in a situation like this the onus on counsel for a coroner, whilst remaining neutral, is to act as an amicus curiae (advocate to the court) and assist to ensure that the court is given the full factual picture, including if necessary by drawing the court's attention to matters not emphasised or omitted by a claimant, as well as alerting it to relevant law and authorities. As it is, the court has had to inform itself about the factual circumstances of the case by going back to the underlying materials and evidence before the Coroner.

118. The Divisional Court dismissed Mrs Maguire's claim. Since the claim in relation to the question of neglect has not been raised in the appeal to the Supreme Court, it is sufficient to mention only the claim in relation to article 2.

119. Ms Butler-Cole's submission in the Divisional Court on behalf of Mrs Maguire was that the Coroner had erred in treating Jackie's death as a healthcare-related death, of the kind discussed in *Parkinson*. Instead, Jackie's death fell within a distinct recognised category of the death of a vulnerable person in the care of the state, and the fact that she died of a physical health condition which required medical treatment did not change that. Ms Butler-Cole emphasised *Fernandes*, para 163 (para 41 above), in order to suggest that the guidance given in that case was not applicable. Instead, Ms Butler-Cole submitted that the enhanced procedural obligation arose under article 2 in a wider class of case than those involving a real and immediate risk to life (as in *Osman*, *Savage* and *Rabone*). She relied on *Centre for Legal Resources*, para 131; *Jasinskis v Latvia* 58 EHRR 21 ("*Jasinskis*"), para 60; *Dzieciak v Poland*, judgment of 9 December 2008, para 91; and *Oliveira*, para 113, to contend that such a procedural obligation existed in Jackie's case by reason of Jackie's vulnerability and the assumption of direct responsibility for her welfare by the state, demonstrated by her placement at the care home and the existence of a DoLS authorisation in respect of that placement; Jackie's

total reliance on paid carers and other professionals for access to medical care; the evidence of failings by a range of bodies and individuals in respect of the medical care given to Jackie; and the background context of a pattern of premature deaths of people with learning disabilities, due to delayed medical treatment.

120. Evidence of this context was filed in the form of reports which indicate that people with learning disabilities generally have a lower life expectancy than those without: "The Learning Disabilities Mortality Review" published by the University of Bristol Norah Fry Centre for Disability Studies in December 2017 ("the LDM Review") and the report of a "Confidential Inquiry into premature deaths of people with learning disabilities" by Pauline Heslop and others, dated March 2013 ("the CIPOLD report").

121. In the alternative, if there was a test of exceptional circumstances and/or a requirement to show systemic failures, this was satisfied. The matters relied on were the absence of an effective communication system between the GP service, the out-of-hours GP service, the NHS 111 service, the ambulance service and the hospital to communicate Jackie's symptoms. Ms Butler-Cole did not contend that there had been a breach of an operational duty based on *Osman*. Nor did she contend that there was a systems failure consisting in either the care home or the ambulance service not having in place a protocol to state that if Jackie needed to be taken to hospital but was resistant, she should be sedated.

122. In what the Divisional Court described as a proper concession (para 47), Ms Butler-Cole accepted that mental incapacity sufficient to justify deprivation of liberty under the MCA 2005 is insufficient on its own to trigger the engagement of the enhanced procedural obligation under article 2.

123. The Divisional Court rejected Ms Butler-Cole's submissions. In their view, the situation which had arisen in Jackie's case fell outside the guidance in *Rabone* and in the absence of either a systems dysfunction or a relevant assumption of responsibility in a particular case, the state would not be subject to a duty to account under the enhanced form of the article 2 procedural obligation: para 44. The failures relied on by Ms Butler-Cole might give rise to civil liability or professional disciplinary proceedings, but were attributable to individual actions or failings and were not capable of demonstrating a systems failure requiring the state to be called to account: para 45. In accordance with Ms Butler-Cole's concession, the death of a person lacking capacity and subject to a DoLS authorisation under the MCA 2005 does not automatically give rise to the enhanced form of article 2 procedural obligation: para 48. Instead, each case turns on its own facts and the extent to which the state has assumed responsibility for the care of that

person, which was a matter for the assessment of the Coroner. The Coroner's assessment was not irrational and involved no error of law; it was open to him to conclude that this was a medical case within the guidance given in *Parkinson*, that a jury could not safely find that Jackie died as a result of any actions or omissions for which the state would be responsible in a relevant sense, and therefore he was right not to invite them to give an expanded form of verdict: paras 48-49.

124. Mrs Maguire appealed to the Court of Appeal on three grounds: (i) the Divisional Court erred either in treating the case as a healthcare or medical negligence case falling within the *Parkinson* line of authorities and thus outside the relevant ambit of the enhanced procedural obligation under article 2, rather than within the parameters for application of the enhanced procedural obligation laid down in *Rabone*, or in applying the *Rabone* principles but concluding that the enhanced form of the article 2 procedural obligation was not engaged; alternatively, (ii) if the Divisional Court were correct to conclude that *Parkinson* applied, they should have concluded that the omission to have in place any mechanism for admitting Jackie to hospital on the evening of 21 February 2017 in the form of an advance plan drawn up by the care home and the GP, or a plan on the part of the ambulance service faced with a patient without capacity in need of admission to hospital but objecting to going, amounted to a systemic failure; and (iii) the Divisional Court erred in failing to take into account the wider context of the premature deaths of people with learning disabilities.

125. The first ground was expanded in submissions to include the contention, not made before the Coroner or in the Divisional Court, that there was a breach of an operational duty as derived from *Osman*, in that there was a failure to take steps to prevent a real and immediate risk to life of which the authorities should have been aware; alternatively, there had been an egregious denial of medical treatment. In her submissions in the Court of Appeal, Ms Butler-Cole again made the concession that the existence of a DoLS authorisation in relation to Jackie was not sufficient in itself to engage the enhanced procedural obligation under article 2.

126. The Court of Appeal (Lord Burnett of Maldon CJ, Ryder and Nicola Davies LJJ) dismissed the appeal: [2020] EWCA Civ 738; [2021] QB 409. They reviewed the Strasbourg case-law, focusing on cases concerned with problems in the provision of medical services, particularly *Fernandes*, *Oliveira*, *Centre for Legal Resources*, *Nencheva v Bulgaria*, judgment of 18 June 2013 ("*Nencheva*"), and *Dumpe*. They also reviewed the domestic case-law, focusing particularly on *Savage*, *Rabone*, *Parkinson* and *Tyrrell*. The Court of Appeal noted (para 28) what was said in *Fernandes* at para 163 (para 41

above), but nonetheless considered that relevant guidance could be derived from that judgment.

127. The principal submission for Mrs Maguire was that the undeniable vulnerability of an individual in Jackie's position, coupled with the fact of a DoLS authorisation, had the effect that she was owed the operational duty under article 2 with the result that the enhanced procedural obligation applied and the Coroner should have instructed the jury to return an expanded form of verdict: para 70.

128. The Court of Appeal emphasised that it was important to focus on the scope of any such operational duty and why it might be owed. They agreed with the Divisional Court that the unifying feature of the application of the duty to protect life was state responsibility: paras 71-72. They distinguished *Nencheva* and *Centre for Legal Resources*, in which the enhanced procedural obligation had been held to apply, and observed that the article 2 substantive obligation "is tailored to harms from which the authorities have a responsibility to protect those under its care": paras 72-73. At para 74 they said:

> "The argument advanced before the coroner, the Divisional Court and us was largely structured around a binary question: is this a *Rabone* case or a *Parkinson* case? That, however, is not the approach of the Strasbourg court. The fact that an operational duty to protect life exists does not lead to the conclusion that for all purposes the death of a person owed that duty is to be judged by article 2 standards."

129. The court emphasised (paras 75-78) that in their view it was necessary to determine the nature or scope of any operational duty owed under article 2 when considering the nature of the procedural obligation arising under article 2. In some cases involving the death of a person in custody or otherwise under the control of the state the enhanced procedural obligation would arise. But in other cases, even though the deceased had been in the custody or under the control of the state, the redress procedural obligation would apply. In the latter class of case, an expanded verdict at the end of an inquest would not be required or permitted.

130. The court reviewed the facts in some detail. They set out their conclusions in relation to grounds (i) and (iii) at paras 96-104. An article 2 operational duty - an arguable breach of which would engage the enhanced

procedural obligation - is owed to vulnerable people under the care of the state for some, but not all, purposes. In the present case, concerned with a death which followed alleged failures or inadequate interventions by medical professionals, the redress procedural obligation under article 2 applied. *Dumpe*, in which the redress procedural obligation was held to apply, provided a close analogy and there was no jurisprudence of the Strasbourg Court which suggested that a relevant operational duty was owed to those in an analogous position to Jackie in connection with seeking ordinary medical treatment; accordingly it would be inconsistent with the principle set out in *R (Ullah) v Special Adjudicator* [2004] 2 AC 323 ("*Ullah*"), para 20, for the domestic courts to find that one existed. In *Dumpe* the principles explained in *Fernandes* were applied.

131. In the view of the Court of Appeal, the caveat in para 163 of the *Fernandes* judgment did not affect the outcome in this case. Jackie's situation was not analogous with that of a psychiatric patient who is in hospital to guard against the risk of suicide. She was not in the care home for medical treatment, and if she needed such treatment it was sought in the usual way from the NHS; "[h]er position would not have been different had she been able to continue to live with her family with social services input and been subject to an authorisation from the Court of Protection in respect of her deprivation of liberty whilst in their care" (para 101).

132. The LDM Review and the CIPOLD report adduced in relation to ground (iii) did not illuminate how, when, where or in what circumstances Jackie came by her death. They did not provide additional weight to the argument that a relevant operational duty was owed to Jackie.

133. In view of these conclusions, the court held (para 102) that it was not strictly necessary to decide whether, according to the test in *Osman*, para 116, on the evening of 21 February 2017 the evidence suggested that the medical professionals knew or ought to have known that Jackie faced a real and immediate risk of death and did all that they reasonably should have done to prevent the risk from materialising. However, the court doubted that there had been a breach of the duty explained in *Osman*. The medical professionals (Dr Adam, Dr Fairchild and the paramedics) collectively did not think that the situation was dangerous, and it was that assessment which underpinned the decision to let Jackie remain at the care home under observation overnight.

134. The Court of Appeal also dismissed ground (ii): paras 105-106. No "very exceptional circumstances" existed of the kind contemplated in *Fernandes*. Jackie's life was not knowingly put in danger by a denial of access to life-saving emergency treatment: the view of the medical professionals was that Jackie was not in danger on the evening of 21 February 2017. Nor was there any

systemic or structural dysfunction in medical services which resulted in Jackie being denied life-saving treatment, by contrast with the description given in *Fernandes* at paras 195-197.

(7) The issues in the appeal

135. The grounds of appeal to this court for which permission was granted are that the Court of Appeal erred (i) in following *Dumpe*; (ii) in limiting the scope and effect of para 163 of the *Fernandes* judgment in the way it did; and (iii) in determining that the conclusion in *Rabone* flowed from the Strasbourg case-law and that Jackie's case fell to be distinguished from *Rabone*.

136. In relation to ground (ii), the appellant's contentions are that there was a relevant operational duty owed to Jackie because she was a paradigm example of a vulnerable person under the care of the state which had direct responsibility for her welfare and that there was a systemic dysfunction by reason of the failure to establish any system for conveying a patient who lacked capacity to make decisions for herself to hospital in the face of non-compliance. Under ground (iii), the appellant's contentions are that neither the domestic nor the Strasbourg case-law supports an argument that self-harm or treatment for mental disorder is a precondition for the enhanced procedural obligation under article 2 to apply in accordance with *Rabone*; alternatively, there was a real and immediate threat to Jackie's life on 21 February 2017 within the meaning of the principle in *Osman*, para 116.

137. The court allowed Ms Richards to argue her case on the basis of a withdrawal of the concession made below (para 122 above) in order to contend that the fact that Jackie was deprived of her liberty while in care was a circumstance which, even taken by itself, meant that a relevant operational obligation was owed to Jackie; but in any event, she argued that such a duty was owed when that factor was taken together with Jackie's vulnerability and the assumption of responsibility towards her on the part of the state.

138. Ms Richards submits that there was (at least) an arguable breach of the systems duty in Jackie's case and/or a breach of an operational duty owed to her, with the result that the enhanced procedural obligation applied and the jury should have been instructed to give an expanded verdict at the inquest.

139. In her written case, Ms Richards substantially reformulated the appellant's case, going beyond the arguments which had been presented to the Coroner and the courts below. Ms Richards expanded on her case in a further note of 36 pages filed after the hearing at the court's invitation, so that it could understand fully the points which she was seeking to make about

alleged arguable breaches of the operational and systemic duties under article 2.

140. Although this was informative, it does not change the nature of the issue for determination in this court, which is whether the Coroner acted irrationally or erred in law in the decision he made as to the verdict he should invite the jury to consider. The Coroner was entitled to proceed on the basis of his assessment of the totality of the evidence he had heard and by focusing on the submissions presented to him by counsel for Mrs Maguire and the opposing submissions of the other interested persons, as summarised above. It would not be appropriate for this court to approach the matter simply as if it stood in the shoes of the Coroner and was hearing the case for the first time. The Divisional Court and the Court of Appeal rightly understood that their function was one of review of the Coroner's decision, not to decide the matter de novo or on the basis of a full appeal on the merits.

141. On the other hand, the Coroner was subject to a statutory duty to conduct an investigation on an inquisitorial basis and to take steps to ensure that, by complying with the duties imposed on him under section 5 of the 2009 Act, the United Kingdom complied with its international obligations under the Convention. In a case like this, where the Coroner was assisted by considered and detailed submissions by counsel for each of the interested persons, he was entitled to focus on the arguments presented in those submissions. He was entitled to expect that counsel for the interested persons could generally be relied on to invite his attention to what they regarded as important and significant in the particular circumstances of the case, and each other interested person was entitled to understand that the main areas of contention and debate between them were identified and framed in this way.

142. However, despite being generally entitled to proceed in this way, it was also incumbent on the Coroner to consider of his own motion any point not raised in submissions which was "obvious" in the sense explained in *R v Secretary of State for the Home Department, Ex p Robinson* [1998] QB 929, 945-946. The question whether there had been a breach of the *Osman* form of operational duty in relation to the failure to take Jackie to hospital on 21 February 2017 was central and an obvious point to be considered. Indeed, the Coroner did consider it, although Ms Formby presented no submissions to him based on this at the hearing on 28 June 2018. Accordingly, the Court of Appeal was right to allow it to be raised in the appeal, even though it had not been distinctly argued before the Coroner or indeed at first instance. This point was also distinctly raised in Mrs Maguire's grounds of appeal to this court for which she was given permission.

143. There is a distinction between the position of the care home and the healthcare providers involved in the case, namely the NHS 111 service, the ambulance service, the GPs and the doctors at the hospital. Unlike the healthcare providers, the care home was not directly responsible for providing medical services to Jackie but did have a responsibility to ensure that, as a vulnerable person in its care, she should have access to medical services. It is convenient to consider the issues which arise on the appeal under the following headings:

(1) Was there an arguable breach of the systems duty on the part of the care home, so as to trigger the enhanced procedural obligation?

(2) Was there an arguable breach of the systems duty on the part of any of the healthcare providers, so as to trigger that obligation?

(3) Was there an arguable breach of the operational duty on the part of the care home, so as to trigger that obligation?

(4) Was there an arguable breach of the operational duty on the part of any of the healthcare providers, so as to trigger that obligation?

(a) Was there an arguable breach of the systems duty on the part of the care home?

144. The Coroner heard evidence about the systems in place at the care home with respect to training staff, maintaining records in relation to residents as to their welfare and health, and taking steps to gain access to healthcare services when required. Further, as the Coroner appreciated, the CQC had a regulatory role in relation to the care home, to ensure that it maintained high standards in relation to the provision of care, and carried out regular inspections to check on this. As the Coroner was aware, the CQC had carried out an inspection shortly after Jackie's death. It had been satisfied with the systems in place at the care home and the standard of care provided there. In my view, the Coroner was entitled to find on the evidence which he had heard by the time of the verdict decision that there was no arguable breach of the systems duty on the part of the care home such as would have the consequence that the enhanced procedural obligation applied.

145. The position in relation to care provided at the care home was essentially the same as that in relation to the systems duty in relation to the provision of healthcare services as discussed in *Powell* (see para 36 above),

and reiterated in *Fernandes*, para 187, and *Oliveira*, para 106. The state has put in place a regulatory regime designed to ensure that a high standard of care is delivered in care homes, which is monitored and enforced by the CQC as the dedicated regulator in this area. As the Strasbourg Court emphasised in *Fernandes*, para 169, in cases concerning medical negligence "the court has rarely found deficiencies in the regulatory framework of member states as such"; and at para 190 (para 50 above) it explained that it was only in "very exceptional circumstances", as described at para 192, that the substantive responsibility of the state under article 2 would be engaged in respect of the acts and omissions of healthcare providers. This indicates that the systems duty in this area operates at a high level, is relatively easily satisfied, and it will only be in rare cases that it will be found to have been breached.

146. It is clear that the systems in place at the care home were capable of being operated in a way which would ensure that a proper standard of care was provided to residents at the home, even though there may have been individual lapses in putting them into effect. As explained in *Humberstone*, para 71, and *Parkinson*, para 91, individual lapses in putting a proper system into effect are not to be confused with a deficiency in the system itself. The same point was made in *Fernandes*, para 195 (para 50 above).

147. There is no sound basis for adopting a different approach to the provision of care in a care home as distinct from in a hospital or other healthcare environment. If anything, one would expect higher (or, at least, equivalently high) standards to be required according to the systems duty under article 2 as it applies to healthcare providers, as they will in many situations be directly on notice of a risk to life in relation to patients in their care to an extent going beyond what would usually be the case in a care home. The individual being cared for may be vulnerable and may suffer a loss of liberty in both environments, but this does not change the application of the systems duty in the healthcare context and it is difficult to see why it should make a significant difference in the ordinary care context. Moreover, in the healthcare context the scope of the systems duty is modulated to take account of the specific type of risk in relation to which the state has assumed a responsibility to protect the individual in the light of his or her specific circumstances, and there is no good reason to adopt any different approach in the ordinary care context.

148. A number of points may be made:

(1) Ms Richards' suggestion that para 163 of the *Fernandes* judgment indicates that the Strasbourg Court positively meant that different principles would necessarily apply in a case involving medical treatment of persons deprived of their liberty is not

correct. In that paragraph the Strasbourg Court was only putting such cases to one side in order to focus on the specific context relevant to its judgment, recognising that those other cases might raise distinct considerations.

(2) Ms Richards' further submission that *Fernandes*, para 163, means that the guidance in the rest of that judgment is of no assistance when considering the case of a person who receives healthcare when they are subject to a loss of liberty is unsustainable. This is clear from the judgment in *Oliveira*, which contained a review of the position in relation to persons at risk of suicide who are detained for treatment as well as those who are voluntary patients (see para 124) and treated the judgment in *Fernandes* as relevant in stating general principles applicable in relation to the systems duty in this area (paras 105-107). Furthermore, the case-law shows that there is no bright-line boundary between persons who are in detention to receive medical attention for mental health problems and those who are voluntary inpatients to receive such attention: see *Rabone*, paras 26-34 (Lord Dyson), 100-106 (Baroness Hale); *Oliveira*, paras 124-132. So it is naturally to be expected that, to the extent that the situation is comparable in the two cases, the guidance given in *Fernandes* is capable of being informative about the obligations owed in a situation where care is provided in a context where, in order for it to be provided, there is a loss of liberty for the individual concerned.

(3) The Strasbourg Court's jurisprudence on the duties owed in cases involving allegations of medical negligence, from *Powell* through *Calvelli* to *Fernandes*, is not directed to carving out an exemption from article 2 in such cases, but reflects the lesser obligation of the state under that provision to exercise control and to give an account in that context. It would not be reasonable to impose a higher standard of duty in respect of what non-medically trained staff in a care home should do as regards giving access to medical treatment or as regards the state's obligation to account for what they do.

(4) An individual such as Jackie is placed in a care home so that they can be provided with a substitute form of familial care when they are no longer able to look after themselves and their family cannot cope either. There may well be a deprivation of liberty according to the standards laid down under article 5 of the Convention, but this is for their own benefit. They are in a situation very different from a prisoner subject to incarceration or detention by the police of the kind referred

to in *Middleton* and *Amin*, which is a context in which there is a heavy onus on the authorities to account where a death occurs. In a care home or a nursing home, loss of liberty is an incidental feature of the vulnerability of the individual resident, and it is the vulnerability and the assumption of responsibility of care in the light of it which is the fundamental basis for the duties owed under article 2. The extent to which an individual may be vulnerable and requiring of protection is on a continuum which is different from the distinction between loss of liberty and freedom for the purposes of article 5. As the Court of Appeal pointed out (paras 68-69), many people, young and old, share Jackie's characteristics of being vulnerable and unable to care for themselves, with increasing numbers of elderly adults being in a similar position as a result of diminished mental faculties or dementia; they may be accommodated in nursing homes or care homes or with their family, and substantial numbers will be subject to the DoLS regime to authorise stopping them from leaving, in the interest of keeping them safe. The stronger analogy in the case of a care home is with a situation in which the state has authorised loss of liberty at a family home in the interests of the individual, rather than with imprisonment. It is appropriate that the duties applicable under article 2 should reflect this different context.

(5) This is borne out by *Dodov v Bulgaria* (2008) 47 EHRR 41 ("*Dodov*"), an influential judgment of the Strasbourg Court cited in *Savage*, *Rabone*, *Fernandes* and *Oliveira*. It concerned an elderly lady without capacity who was admitted to a nursing home where she required constant supervision and the staff had been instructed not to leave her unattended. She was accompanied by a medical orderly to a doctor's appointment outside the home and was left unattended for a while, as a result of which she wandered off, was never found and was presumed dead. The court considered the case according to the principles laid down in *Powell* and *Calvelli* in the context of allegations of medical negligence: paras 79-83 and 87. At para 81 the court noted that, unlike *Calvelli*, which concerned errors by medical doctors, the negligent act that endangered life was committed "by a medical orderly and/or technical auxiliary staff", but equated the two situations: "there is no reason why the requirement to regulate the activities of public health institutions and afford remedies in cases of negligence should not encompass such staff, in so far as their acts may also put the life of patients at risk, the more so where patients' capacity to look after themselves is limited, as in the present case." Applying the approach in *Calvelli*, the court found a violation of the procedural obligation under article 2, principally because of excessive delay in the

determination of a civil claim brought in respect of the incident: paras 87-98.

149. *Dumpe* provides further support for this approach. It concerned the death of the applicant's son, who had Down's syndrome and epilepsy and was placed in a state-run social care home. There was an issue whether he received adequate care there. He became unwell, so an ambulance was called and he was taken to hospital. He was found to be undernourished and seriously unwell, with potential viral hepatitis and other health problems. His condition deteriorated, he fell into a coma and three days after his admission to hospital he died. The applicant complained that her son had died because he had not been provided with adequate medical assistance, because the personnel at the care home did not react in good time to the deterioration in his health. The domestic investigations had concentrated on potential negligence of medical personnel and had not addressed the question of whether the death had been caused by the inadequate care at the home. The Strasbourg Court dismissed the application on the grounds of failure to exhaust appropriate domestic remedies.

150. The court noted (para 56) that there was nothing to indicate that the death was caused intentionally. It observed that the case should be distinguished from cases where the domestic authorities had been aware of appalling conditions at a care home and had nonetheless unreasonably put the lives of people resident there in danger (*Nencheva* and *Centre for Legal Resources*), and also from *Jasinskis*, which concerned the authorities' failure to provide a detained individual with the emergency medical care necessary to safeguard his life.

151. By contrast, in *Dumpe* the deceased died owing to the care home's, in particular its medical staff's, failure to provide him with adequate medical care when his health condition deteriorated; therefore the complaint pertained to medical negligence in the care provided to the deceased: para 57. There was no allegation of a failure to put in place an effective regulatory framework and the complaints did not fall under the very exceptional circumstances in which the responsibility of the state may be engaged under the substantive limb of article 2 (*Fernandes*, paras 190-192); accordingly, "the examination of the circumstances leading to the death of the applicant's son and the alleged responsibility of the healthcare professionals involved are matters which must be addressed from the angle of the adequacy of the mechanisms in place for shedding light on the course of those events. These aspects fall to be examined under the procedural obligation of the state ([*Fernandes*], para 199)": para 58. The applicant could have brought a civil

claim for negligence against the care home and its staff, and this was sufficient to satisfy the state's procedural obligation.

152. The applicant had not exhausted domestic remedies, because she had not pursued this avenue of redress. Accordingly, the application was dismissed on the footing that the court considered that the enhanced procedural obligation was not applicable in the circumstances of the case; had it been applicable, so that the state was under a duty to take the initiative itself to launch and carry out an investigation, it would not have been possible to say that the application could be dismissed in the way it was. The court distinguished the detention case of *Jasinskis*, notwithstanding the fact that the deceased had been subject to loss of liberty in a state-run care home at the time it was alleged he had not been given access to adequate medical assistance to prevent his death.

153. In the present case, the general regulatory framework for care homes under the auspices of the CQC was supplemented by specific systems in place at the care home, which were themselves the subject of checks by the CQC. This met the requirement discussed in *Calvelli*, *Dodov*, *Fernandes* and *Oliveira* for such specific systems to be in place below the level of the general national regulatory framework referred to above. In particular, in *Fernandes*, para 166, and *Oliveira*, paras 103 and 105, the Strasbourg Court said that the systems duty requires the state "to put in place a regulatory framework compelling hospitals to adopt appropriate measures for the protection of patients' lives"; and it is apparent from its discussion of this at *Oliveira*, paras 116-122, that this may potentially involve a requirement to have policies in place appropriate for a specific institution providing care in a particular context. As stated in *Savage*, para 45, the systems duty extends down to particular institutions having appropriate training and procedures in place (see also *Fernandes*, para 189: para 49 above). The Coroner examined the detailed and specific systems in place at the care home, as well as those in place for the various healthcare providers, and concluded that there was no breach of the systems duty in relation to them. On the evidence presented to him, he was entitled so to find.

154. In the appellant's written case it was submitted that Jackie's death was (at least arguably) caused by, in particular, a failure of a number of interconnected public bodies to establish a system by which the health of an individual who lacked capacity either to demand or consent to treatment could be monitored or safeguarded, complaining of an absence of any centralised system to collate and communicate health needs of vulnerable persons; the absence of any effective system for communicating information between the healthcare providers such as the NHS 111 service and the ambulance service; a lack of training in or understanding of the implications of

the MCA 2005; and the absence of an effective system to record the medical history of a vulnerable individual like Jackie in such a way that it could be communicated speedily and accurately between health professionals.

155. In my view, none of these complaints is made out. The Coroner investigated these issues at the inquest and was entitled to find that there was no arguable breach of the systems duty in relation to them.

156. The Coroner heard evidence about the failure of the NHS 111 service to pass on fully the information it had been given on the evening of 21 February 2017 and about how the NHS 111 system was set up to operate, including with a back-up system if its usual computer system malfunctioned, as it did on that occasion. Clearly, as a system, it was capable of operating effectively. The reason it happened not to work perfectly that day was due to individual lapses, not the inadequacy of the system as such.

157. The Coroner heard evidence about the systems in place at the care home and with the various healthcare providers and again was entitled to find that they were capable of being effective to record and share relevant information pertaining to the health of a vulnerable person like Jackie, so that any problems that occurred should again properly be ascribed to individual lapses rather than deficiencies in the system. Further, as stated in *Fernandes*, para 168, negligent coordination among health professionals in the treatment of a patient is not sufficient to call a state to account from the point of view of its positive obligations under article 2.

158. As regards an understanding of what should be done in relation to the provision of healthcare to a vulnerable individual without the mental capacity to make decisions regarding their care or medical treament, the Coroner heard evidence about the systems and training in place at the ambulance service for this and was entitled to find there was no arguable breach of the systems duty. It was also clear from the evidence that the care home staff and all the relevant healthcare professionals understood that Jackie was lacking in capacity and that this meant that a decision about whether she should be taken to hospital would have to be taken in the light of an assessment of her best interests, which is what was required under the MCA 2005: see the discussion at paras 207-208 below. So even if there had been a failure in this respect in relation to the systems duty, it would not have had any causative effect and hence, for this reason also, this would not have been sufficient to raise an issue under article 2: *Fernandes*, paras 188 and 196; *Oliveira*, para 107.

159. Two comments are relevant here. First, this aspect of the appellant's case involved a strong element of "reverse engineering" in terms of trying to

formulate the obligations said to be owed under the umbrella of the systems duty, by looking at what happens to have gone wrong in Jackie's case and then trying to formulate an alleged obligation tailored to that case. But the authorities show that the proper approach to the systems duty is more forward-looking than this, and requires an assessment of the systems which it is generally reasonable to expect the relevant body to have in place in advance of any particular incident. So far as that is concerned, the view of a domestic regulator such as the CQC or the bodies responsible for oversight of the healthcare providers that suitable systems are in place will usually be powerful evidence that the systems duty has been satisfied, since that is precisely how they have to approach that question. It is in large part for this reason that it is only in rare cases that a breach of the systems duty will be found: see *Fernandes*, paras 169 and 192.

160. Secondly, the appellant's formulation of these alleged aspects of the systems duty would potentially have significant implications in terms of the resources required to improve systems. One can almost always say that a system could be improved and made more effective by dedicating more resources to its operation, for instance by trying to create more comprehensive and effective ways to record and share information. But the Strasbourg Court has emphasised that it is not for the court, but rather for the competent authorities of a contracting state to consider how their limited resources should be allocated between competing priorities: *Fernandes*, para 175. This principle underscores how limited are the circumstances in which it will be appropriate to find a breach of the systems duty.

161. In the event, Ms Richards' principal oral submission was that there was (at least arguably) a breach of the systems duty on the part of the care home because it did not have in place a protocol in relation to Jackie to record her unwillingness to receive medical treatment or go to hospital and to propose that sedation should always be given or at least considered in such circumstances.

162. I do not think that it is open to Ms Richards to make this submission at this stage of the proceedings, since it was not an issue raised before the Coroner; nor was it an issue raised in pleaded case nor as a distinct point in the the courts below. As a result, we do not have the benefit of any evidence from the care home, expert witnesses or others as to whether it would have been reasonable, or even sensible, to have put such a protocol in place.

163. It would be difficult to formulate a protocol which specified in advance with precision how an individual ought to be treated in relation to every possible scenario which might arise. It seems inevitable that how an individual without capacity who is resident at a care home or a nursing home, or who is

taken to hospital, ought to be treated in any given situation will require a high degree of individual assessment on the part of the persons who are dealing with them, according to judgments to be made in the light of the particular circumstances obtaining at the time. There is a distinct risk that if one tries to specify in advance how access to healthcare should be secured, a rigid adherence to such a protocol can result in a failure to treat an individual in an appropriate way: see, eg, *Arskaya v Ukraine*, judgment of 5 December 2013 ("*Arskaya*"), paras 20 and 86. The Strasbourg Court is resistant to allegations, based essentially on "reverse engineering", that strict rules about how the state should provide assistance to preserve life ought to be laid down in advance in order to comply with the systems duty: see *Furdík v Slovakia*, decision of 2 December 2008 (complaint that the system for a helicopter to carry out a mountain rescue failed to specify that this should be done within a set period of time was found to be manifestly without reasonable foundation).

164. But in any event, on the material available to us, I consider that this is a point without merit. It is clear from *Oliveira* that the fact that a system in place at a hospital calls for the exercise of judgment by clinicians or others in light of the specific circumstances of a case does not show that the system is deficient: see, in particular, paras 118-119 and the discussion at paras 54-56 above.

165. The systems in place in the present case were capable of being operated in a timely and effective way. The care home staff appreciated that they should call for medical help if a resident was experiencing significant health problems, and they did. The paramedics attending on 21 February 2017 also appreciated that they could call for medical advice if they felt it was needed, and they did.

166. The paramedics were aware of the possibility of sedation, although they could not administer it themselves, and if a doctor thought it should be administered the system allowed for that to happen. It was not obviously in Jackie's best interests, whether from a purely physical or from a wider perspective (see paras 54-60 above) that she should be sedated in order to remove her to hospital; and it would not have been reasonable to have a protocol in place which required that to happen whatever the situation on the ground might be. If the protocol did not require sedation, but only consideration of it, it would not have avoided the need for an individual assessment to be made in the light of all the circumstances and so it is not apparent that it would have achieved any significant difference in treatment.

167. In the event, the judgment of Dr Adam and Dr Fairhead was that Jackie did not need to be taken to hospital, whether by sedation or by use of

restraint. In this context, *Fernandes,* paras 169 and 192, again indicates that there was no arguable breach of the systems duty in this case.

168. Ms Richards also relied on *Arskaya*, *Tarariyeva v Russia* 48 EHRR 26 ("*Tarariyeva*"), *Gültekin v Turkey,* judgment of 6 October 2015 ("*Gültekin*") [2015] ECHR 836, *Legal Resources Centre* and *Nencheva* in relation to both the systems duty and the operational duty. However, these authorities do not support her case.

169. In *Arskaya* the applicant's son died shortly after being hospitalised when he fell severely ill, suffering from an acute abscess of the lung. The regulatory framework in place governing access to intensive medical care, which was only available at one city hospital, was too rigid and prevented him from having access to such care: paras 20 and 86. The deceased had also become mentally disordered, and there was no set of rules in place for establishing whether he lacked decision-making capacity, so that his refusal to consent to treatment was accepted at face value: paras 87-88. These features of the regulatory framework meant that he was prevented from having access to treatment: see *Fernandes*, para 170. By contrast, in the present case there was nothing in the regulatory regime to prevent Jackie having access to emergency healthcare in hospital, if the doctors and paramedics considered it was appropriate to take her there; and they understood very well that she did not have capacity to decide what treatment she should receive and that she could and should be taken to hospital if that was assessed to be in her best interests.

170. *Tarariyeva* concerned the death of a prisoner. He fell ill and doctors diagnosed a serious ulcer for which medication was prescribed. However, when he was returned to prison, it was alleged that he did not receive medical assistance. The prison authorities were aware of his serious health problems but failed to ensure that his health was checked, so he was not provided with any appropriate medical care at that stage (para 80). Some four months later, after complaining of acute pain, he was diagnosed as having a perforated ulcer and peritonitis and was operated on at a public hospital. Notwithstanding continuing serious problems of which the doctors at the public hospital were well aware (including the breakdown of sutures from the operation) which called for immediate further surgery, he was discharged from the hospital and transported back to the prison hospital. The failure to provide medical assistance at this stage aggravated his condition and led to complications (para 84). After a further delay in provision of treatment which was unexplained (para 86), about two weeks later, after undergoing further surgery at the prison hospital, which was not properly equipped with blood-transfusion facilities necessary for such an operation (para 87), the prisoner died.

171. The Strasbourg Court held, among other things, that there had been a violation of the substantive positive obligation under article 2: paras 88-89. This was an egregious case of non-provision of medical care which was known to be required, which in substance involved a failure to make available medical assistance of a kind generally available, in violation of the aspect of the positive obligation referred to at paras 22 and 46-49 above.

172. *Gültekin* is another case of this type. There, a military conscript fell ill with acute hepatitis and the examining doctor told the military authorities that he should be transferred to hospital for treatment. They failed to act on this advice for a period of seven days, by which time it was too late to save the conscript, who died: paras 35-42, 45 and 48. A breach of the substantive obligation under article 2 was found because the authorities had not done everything they reasonably could have been expected to do to safeguard his life, by acting in accordance with the medical advice received.

173. In *Nencheva* the applicants were parents of children who died while being kept at a home for children with serious mental disorders. As the director of the home warned the authorities, it had been deprived of financial resources so that it lacked the material means to meet the basic needs of the children as regards heating, cleaning and provision of food, so that their lives were at imminent risk. 15 children died over the winter months in what amounted to a national tragedy. The Strasbourg Court found a violation of the substantive positive obligation under article 2.

174. The authorities had undertaken to care for the children at the home, who were vulnerable persons with serious mental and physical disorders (para 119). They were subjected to the worst possible living conditions, which inevitably put their lives at risk (para 121). The authorities had been specifically put on notice of the risk (para 121). The increased mortality rate was apparent over a long period, so that in "the exceptional circumstances" of the case the approach in *Powell* in relation to ordinary cases of medical negligence was not applicable (paras 122-123 and 125). The authorities had had knowledge of the real and imminent risks to the lives of the children but failed to take appropriate measures to protect them (para 124). Again, this case can be analysed as one where there was a complete denial of access to healthcare, with the authorities failing to ensure that vulnerable individuals had access to the healthcare services available to the general population (paras 22 and 46-49 above). It meets the high threshold for breach of the systems duty set out in *Fernandes*, para 192 (para 50 above). It can also be analysed in terms of a straightforward violation of the *Osman* operational duty. Such complaints are not sustainable in the present case.

175. *Centre for Legal Resources* concerned a young man with profound intellectual disability who was also HIV-positive. After he left a state orphanage in Romania aged 18, there was a period when he received no effective care, before being admitted to a care centre in an advanced state of psychiatric and physical degradation, suffering from malnutrition, dressed in a tattered tracksuit with no underwear or shoes, with no antiretroviral medication or information about his medical condition, and unable to eat or care for his personal hygiene by himself (para 14). He became agitated, was given drugs to calm him, and was taken to a psychiatric hospital for assessment, where he was prescribed sedatives and discharged back to the care centre. His condition deteriorated and he again became agitated. He was transferred back to the hospital, where he stopped eating and refused to take his medication. He was held there for seven days with seriously inadequate nutrition and care, since the staff refused to help him for fear they would contract HIV. A team of monitors from the Centre for Legal Resources ("CLR") who visited him at this time reported that the hospital had failed to provide him with the most basic treatment and care services; they asked for him to be transferred immediately to an infectious diseases hospital where he could receive appropriate treatment, but this was refused (para 23). He died that evening from cardiorespiratory insufficiency (para 24).

176. The CLR brought various sets of domestic proceedings to elucidate the circumstances of his death, and then made an application to the Strasbourg Court on his behalf, claiming a breach of article 2 (among other provisions). At paras 130-133 the court set out the general principles to be applied. It referred (para 130) to the systems duty identified in *Calvelli*, para 49, and said "This applies especially where patients' capacity to look after themselves is limited [citing *Dodov*, para 81]"; it also cited *Nencheva*, paras 105-116, and *Jasinskis*, para 59. At para 132 it cited *Calvelli*, para 53, in relation to civil proceedings being sufficient to satisfy the procedural obligation under article 2 in a case of negligence. The court found that the deceased had been placed in the care centre and the hospital which did not have the necessary facilities to treat him, having regard to his HIV (para 136); his transfers between units "took place without any proper diagnosis and aftercare and in complete disregard of his actual state of health and his most basic medical needs", including by failing to implement the antiretroviral treatment he required and to provide access to psychiatric treatment or an assessment by an infectious-diseases specialist (paras 137-138); the actual cause of death was not properly identified by the state authorities, but according to an expert instructed by the CLR there were several possibilities (including pneumonia) which had never been investigated or diagnosed, let alone treated (para 139).

177. The Strasbourg Court found that the situation was comparable to that in *Nencheva*, since the authorities were fully aware that the situation at the

psychiatric hospital was difficult at the relevant time, with a lack of heating and appropriate food and a shortage of medical staff and medical resources, including medication; in deciding to place the individual in the psychiatric hospital, notwithstanding his already heightened state of vulnerability, the domestic authorities unreasonably put his life in danger; and the continuous failure of the medical staff to provide him with appropriate care and treatment was yet another decisive factor leading to his untimely death (para 143). Accordingly it found a violation of the substantive positive obligation under article 2. The court also found that there had been a breach of the procedural obligation. This was a clear case of a complete failure to provide basic medical assistance which was known to be required. It is of an entirely different character from the present case.

178. Finally under this heading, Ms Richards relied on *Traskunova v Russia*, judgment of 30 August 2022 ("*Traskunova*"). This concerned the death of a participant in clinical trials of a new medicinal product for the treatment of schizophrenia, a mental illness from which she suffered. She died from cardiovascular problems associated with the trials. Her health had not been properly monitored during a first trial and she was not screened for medical fitness in relation to a second, nor advised about the possible serious cardiotoxic effect of the product (para 40).

179. The Strasbourg Court analysed the case (para 69) in terms of the systems duty, referring in particular to *Fernandes*, paras 186 and 189. The court observed that the case could not be treated as one of ordinary medical negligence. Rather, a clinical trial of a new product is a form of dangerous activity which engages the state's positive obligation to ensure through a system of rules and through sufficient control that the risk is reduced to a reasonable minimum; in the context of dangerous activities of this kind, "the Court has placed special emphasis on regulations geared to the special features of the activity in question", including by making it compulsory for all those concerned to take practical measures to ensure the effective protection of citizens whose lives might be endangered by the inherent risks; if damage arises, "it will only amount to a breach of the state's positive obligations if it was due to insufficient regulations or insufficient control, but not if the damage was caused through the negligent conduct of an individual or the concatenation of unfortunate events" (paras 72-73). The basic requisite regulatory framework was in place and was satisfactory (para 75). However, the practical implementation of the framework was deficient and the guarantees to ensure the giving of informed consent of participants were not complied with, with the result that there was a breach of the state's substantive positive obligations on that basis (paras 76-80).

180. Ms Richards submitted that *Traskunova* shows that no distinction is in fact to be drawn between breach of the systems duty and breach of the operational duty. I do not accept this. It is contrary to the clear case-law reviewed above which draws precisely that distinction. In fact, as explained above, that case concerns the application of a special form of the state's substantive positive obligation under article 2, which is concerned with the regulation of the conduct of dangerous activities promoted by the state where risk to life is known to be inherent in the activity. In that context, as the Strasbourg Court emphasised in the judgment, the obligation to ensure direct enforcement of the regulatory regime for the reduction of the risk is heightened. Even then, the distinction between the systems duty and the operational duty is maintained (para 73). However, the context of the present appeal is very different. Jackie was placed at the care home so that she could be looked after in a general way. The state was not promoting her participation in an inherently dangerous activity for which it was responsible.

181. For these reasons, I would dismiss the appellant's submission that the enhanced procedural obligation arose by reason of an arguable breach of the systems duty by the care home.

(b) Was there an arguable breach of the systems duty on the part of the healthcare providers?

182. The arguments and the analysis under this heading are closely similar to those in relation to the care home. As regards the provision of healthcare by trained personnel it is clear that the approach in *Powell*, *Calvelli* and *Fernandes* is applicable.

183. The Coroner examined the training and understanding of ambulance paramedics in relation to dealing with individuals lacking capacity, including in relation to the MCA 2005, and identified no problem with this. For ambulance crews, dealing with such individuals will be a common experience and the standards to be applied are subject to general regulatory overview of ambulance services in the usual way. The paramedics did in fact approach the question of whether Jackie should be removed to hospital on 21 February 2017 by assessing what was in her best interests, including by seeking medical advice, so their conduct tended to confirm that the system under which they were working was appropriate and effective.

184. I would therefore dismiss the appellant's submission that the enhanced procedural obligation arose by reason of an arguable breach of the systems duty in respect of the various healthcare services provided to Jackie. Clearly, criticisms could be made of aspects of the conduct of Dr Adam and Dr

Fairhead, as was explored at the inquest. But these related to lapses in individual performance, not a failure as regards the systems duty.

(c) Was there an arguable breach of the operational duty on the part of the care home?

185. As regards the operational duty, Ms Richards submitted that the enhanced procedural obligation applied in this case because of an arguable breach of the operational duty which arose by reason of the combination of deprivation of liberty, Jackie's vulnerability and assumption of responsibility by the state for her care. I have already addressed the significance of the first two factors, which do not distinguish the present context from the context of allegations of medical negligence where the enhanced procedural obligation does not arise. In my view, Ms Richards also overstates the degree of assumption of responsibility in Jackie's case and its effect on the procedural obligation.

186. The issue of assumption of responsibility raises the question, assumption of responsibility for what? The authorities show that the degree to which assumption of responsibility is a factor relevant to the operational duty under article 2 depends upon the specific risk to life of which the authorities were aware and which they understood had to be guarded against.

187. In *Rabone*, at paras 22-25, Lord Dyson identified factors relevant to finding an assumption of responsibility in the context of provision of care for a vulnerable person, including referring to an individual's heightened vulnerability by reason of their physical or mental condition and focusing on "the nature of the risk" (para 24); at para 30 he emphasised the different nature of the risk presented by a psychiatric patient at risk of suicide from the risk to a patient in an ordinary hospital setting from a life-threatening physical illness, pointing out that in the former case "given the patient's mental disorder, her capacity to make a rational decision to end her life will be to some degree impaired. She needs to be protected from the risk of death by those means"; and at para 34 he said, "if there was a real and immediate risk of suicide … of which the [hospital] trust was aware or ought to have been aware, then in my view the trust was under a duty to take reasonable steps to protect Melanie [the deceased] from it". See also the judgment of Baroness Hale at paras 104 (breach of an *Osman*-type operational duty "will depend upon the nature and degree of the risk and what, in the light of the many relevant considerations, the authorities might reasonably have been expected to do to prevent it") and 105 (the operational duty was engaged because the patient "was admitted to hospital precisely because of the risk that she would take her own life. The purpose of the admission was both to prevent that

happening and to bring about an improvement in her mental health such that she no longer posed a risk to herself").

188. In *Fernandes*, at para 191 (para 50 above), the Strasbourg Court emphasised that the operational duty would only arise in "a specific situation where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment", meaning treatment directed to addressing that specific situation.

189. In *Oliveira*, at paras 108-115 and 124-126, the Strasbourg Court adopted an approach equivalent to that in *Rabone*. It emphasised that the operational duty arises "in certain well-defined circumstances" (para 108); referred to the duty in *Osman*, which was targeted on the specific risk of which the authorities were aware, and explained that the same targeted approach to prevent such a specific risk from materialising was applicable in cases involving risk of suicide (paras 109-110); and held (para 125) that where the authorities knew or ought to have known that an individual posed a real and immediate risk of suicide, the issue was whether they had acted appropriately "to prevent that risk by putting into place the restrictive measures available". See also *Morahan*, paras 48-50 (referring to *Rabone*), 59-60 (referring to *Oliveira*) and 124-130.

190. When an individual is placed in a care home, a nursing home or a hospital, the state's operational duty in the targeted sense derived from *Osman*, para 116, does not involve an assumption of responsibility extending to taking responsibility for all aspects of their physical health, with the consequence that if he or she dies from some medical condition which was not diagnosed and treated in time the state's duty is engaged and the enhanced procedural obligation in terms of accountability is triggered. Even though the individual may not be at liberty, the state is not for that reason made the guarantor of the adequacy of healthcare provided to them in all respects, with an enhanced obligation to account if things go wrong. That would not be consistent with the established approach in relation to cases of alleged medical negligence and the approach adopted in the suicide risk cases discussed above.

191. I agree with Popplewell LJ's comment in *Morahan* (para 48), that "[t]his is consistent with principle because the article 2 operational duty is not one to take steps in the abstract, but rather to take steps to avert a specific risk to life; until the specific risk to life has been identified, it is impossible to answer the duty question. Just as in the domestic tortious law of negligence it is not sufficient merely to ask, 'Is there a duty' but rather, 'Is there a duty not carelessly to inflict a particular type of damage?', so too the article 2 operational duty must be examined and defined as a duty to take reasonable

steps to avoid the specific risk to life which is relevant in the circumstances of a given case."

192. The Court of Appeal in the present case, at paras 71-78, focused their analysis on the specific risks to Jackie's health of which the authorities were aware. In my view, this was the correct approach. As regards the enhanced procedural obligation in the context of the operational duty, it is only if the appellant can show that there was an arguable breach of the operational duty, targeted on a specific risk to Jackie's life which was known or which ought to have been known, that this obligation will be triggered.

193. The requirement to focus on a specific risk of which the authorities are aware and which they have a special responsibility to protect against, so as to inform the extent of their obligations under article 2, is also supported by the domestic case of *Tyrrell* in 2016 and *Kats v Ukraine* 51 EHRR 44 ("*Kats*").

194. *Tyrrell* concerned the death of an individual serving a long prison sentence. There was a failure to diagnose a tumour, so that he received treatment too late and, having been transferred to hospital (where he remained in custody), he died. The death was notified to the coroner, who obtained evidence from the treating doctors and was provided with an expert medical report commissioned by the deceased's family for the purpose of the inquest. That report provided no foundation for any suggestion of negligence on the part of the medical practitioners in relation to the late diagnosis of the tumour, nor of any systemic failings in the medical care provided by or through the prison medical services or the NHS. In the light of the information the coroner obtained, he decided that no further investigations were called for pursuant to article 2 and recorded a simple verdict of death by natural causes.

195. The family challenged that decision, claiming that the coroner was required to hold a *Middleton*-style inquest at which the issue of whether there was negligence in the late diagnosis of the tumour could be explored further. The claim was dismissed by the Divisional Court (Burnett LJ and Lang J). They held that there was no automatic procedural obligation to hold a *Middleton*–style inquest where a person dies in the custody of the state. The enhanced procedural obligation arises only in circumstances where the responsibility of the state is engaged in the sense that there is reason to believe that the substantive positive obligations under article 2, as identified in *Middleton*, have been breached by the state. In the case of deaths in custody this form of the procedural obligation will be triggered in the case of all suspicious deaths, including apparent suicides (that is, in the terminology used in *Morahan*, it will apply automatically in such cases).

196. At paras 22-24 of *Tyrrell*, Burnett LJ referred to *Kats*, in which a prisoner died from an HIV related illness. The prison authorities had been aware of the deceased's HIV status, there had been a striking failure to give her medical attention and her death was the result of inadequate medical assistance. The Strasbourg Court found a breach of the state's substantive positive obligations under article 2 and held that the enhanced procedural obligation applied and had been breached as well. The Strasbourg Court reiterated (para 103) that the state was under an obligation to take appropriate steps to safeguard the lives of those within its jurisdiction. At para 104 it said (omitting references):

> "Persons in custody are in a particularly vulnerable position and the authorities are under an obligation to account for their treatment. Having held that the Convention requires the State to protect the health and physical well-being of persons deprived of their liberty, for example by providing them with the requisite medical assistance … the Court considers that, where a detainee dies as a result of a health problem, the State must offer an explanation as to the cause of death and the treatment administered to the person concerned prior to his or her death. As a general rule, the mere fact that an individual dies in suspicious circumstances while in custody should raise an issue as to whether the State has complied with its obligation to protect that person's right to life."

197. As Burnett LJ pointed out (para 24), the Strasbourg Court was here making two distinct points: (i) whenever someone dies in custody the state must provide an explanation of the cause of death and the medical treatment provided (which is the basic procedural obligation referred to in para 14 above); and (ii) a suspicious death in custody inevitably raises the question of a breach of article 2 on the part of the authorities, in which case the enhanced procedural obligation of the sort at issue in *Middleton* arises. At para 26, Burnett LJ referred to the obligation at (i) as an aspect of "the positive obligations" under article 2 (meaning the substantive positive obligations) and to the obligation at (ii) as "the procedural obligation". However, this is just a matter of terminology. Obligation (i) is itself procedural in nature and, whatever label one gives to it for the purposes of exposition, obligation (ii) is also an aspect of the positive obligations which arise pursuant to article 2: see paras 12 and 39 above. The important point is the difference between these two forms of the procedural obligation. As Burnett LJ observed (para 26) the

distinction between these forms of the procedural obligation is principled; it reflects the ruling by Lord Bingham in *Middleton* at para 5: "The death of any person involuntarily in the custody of the state, other than from natural causes, can never be otherwise than a ground for concern." See also *R (L (A Patient)) v Secretary of State for Justice* [2008] UKHL 68, [2009] AC 588, para 59 (Lord Rodger). It is this concern which is the foundation for the application of the enhanced procedural obligation in that type of case.

198. In *Kats*, para 115, the Strasbourg Court referred to the general obligation on the state to ensure an adequate response, judicial or otherwise, so that the legislative and administrative framework set up to protect the right to life is properly implemented, and identified the application of the enhanced procedural obligation as arising "when a detainee dies in suspicious circumstances". In *Tyrrell*, the claimants submitted that the same enhanced procedural obligation which the Strasbourg Court has applied to cases involving violent deaths in custody should apply in relation to any death in custody, whatever its cause. The Divisional Court rejected this submission. They also dismissed the claim that the coroner had erred in law in failing to conduct a full *Middleton*-style inquest leading to an expanded form of verdict. By the time the coroner made his decision, the evidence showed that the deceased had died from natural causes and there was no reason to suppose that the prison authorities, on behalf of the state, had failed to protect his health and well-being. Therefore, the coroner had been correct to rule that the enhanced procedural obligation did not arise.

199. In the present case, the operational duty applied to the staff at the care home in a graduated way, depending on their perception of the risk to Jackie. They were obviously aware that Jackie was a vulnerable person in their care for the general purpose of looking after her. They were not medically trained. By reason of the placement by the Council of Jackie at the care home, their responsibility was to look after Jackie on behalf of the state in substitution for her family. In view of Jackie's vulnerability and limited ability to look after herself, they had the task of ensuring that she could have access to the healthcare which is available to the population generally, in the same way that a family could secure access for a vulnerable member: *Fernandes*, para 173 (see paras 22 and 46-49 above).

200. When Jackie became seriously unwell on 21 February 2017, this is what the care home staff sought to do. Their conduct was investigated in detail at the inquest. Dr Goode's evidence was that they had behaved in an appropriate way and were not to be criticised: paras 104-105 above. Having sought medical advice, the care home staff were obviously entitled to rely upon the advice they received, which was that Jackie's life was not in danger and she did not need to be removed to hospital that day. In the event, Ms

Formby, as counsel for the family, did not allege that they had breached an *Osman*-style operational duty.

201. In my view, so far as the care home is concerned, *Jasinskis* provides helpful guidance as to what would be expected. In that case, the applicant's son, who was a vulnerable individual who was deaf and mute, was involved in an incident during a night out in which there was minor damage to property and he was pushed and fell backwards down stairs, where he hit his head and lost consciousness for several minutes. The police arrived, were informed about the incident and the individual's disability and what had happened to him, and decided not to wait for an ambulance which had been called but to take him into custody to initiate proceedings for petty hooliganism and public drunkenness. He was not medically examined but was left in a room at the police-station, despite banging on the walls, and despite the police being unable to wake him in the morning, until the following afternoon, when the applicant finally managed to persuade the police to call an ambulance to take him to hospital. He died a few hours later. A post-mortem examination concluded this was from severe head injuries.

202. The Strasbourg Court found a violation of the substantive positive obligation under article 2 and of the procedural obligation. It observed (para 59) that persons in custody are in a vulnerable position and the authorities are under a duty to protect them; "[w]here the authorities decide to place and maintain in detention a person with disabilities, they should demonstrate special care in guaranteeing such conditions as correspond to his special needs resulting from his disability"; and they have a duty "to provide effective protection of vulnerable persons from ill-treatment of which the authorities had or ought to have had knowledge"; "[f]urthermore, the national authorities have an obligation to protect the health of persons who have been deprived of their liberty" (para 60); arising from these points, the court said (para 61):

> "The court considers that the question to be resolved first is whether the [police officers] knew or ought to have known about the danger to the applicant's son's health. Subsequently the Court has to evaluate whether the officers in question displayed adequate diligence in light of the medical condition of the applicant's son and his disability in so far as they knew or ought to have known about them."

203. The court found a violation of the substantive positive obligation since the police officers knew about the son's disability and that he had hit his head and lost consciousness, but kept him in detention for several hours without any medical examination before an ambulance was called. They had thereby failed to fulfil their duty to safeguard his life by providing him with adequate medical treatment (paras 62-67). The court also found a violation of the procedural aspect of article 2, according to the enhanced procedural obligation. It referred to *Calvelli* and observed (para 73) that where a death has not been caused by use of force or similar direct official action "the standard against which the investigation's effectiveness is to be assessed may be less exacting", but emphasised that if the negligence attributable to state officials or bodies goes beyond an error of judgment or carelessness, "in that the authorities in question, fully realising the likely consequences and disregarding the powers vested in them, have failed to take measures that have been necessary and sufficient to avert the risks to the victim's life" the enhanced procedural obligation will apply; and that was the situation in that case.

204. In my view, applying the court's approach in *Jasinskis* in the context of the present case leads to the conclusion that, by the time of the verdict decision, there was no arguable breach of the operational duty by the care home. The care home staff were aware that Jackie was experiencing very significant health problems on 21 February 2017, and if they had done nothing to seek medical advice about them that might well have constituted a breach of the article 2 operational duty. But, unlike the police in *Jasinskis*, they did take appropriate steps to seek medical advice and to call an ambulance. They ensured that Jackie was given access to the healthcare available to the population generally (*Fernandes*, para 173; and paras 22 and 46-49 above). They were then entitled to rely on the judgment of the doctors and paramedics about whether Jackie needed to be taken to hospital. I would therefore reject the appellant's submission that the enhanced procedural obligation arose by reason of an arguable breach of the operational duty on the part of the care home.

(d) Was there an arguable breach of the operational duty on the part of the healthcare providers?

205. The critical issue under this heading is whether there was a breach of the operational duty involved in the decision on 21 February 2017 not to take Jackie to hospital, before the risk of death as identified by Dr Goode increased dramatically. The paramedics and the GPs advising on that date thought it would be advisable for Jackie to go to hospital for checks, but they did not consider that Jackie's life would be in danger if she was not taken there.

Moreover, when assessing whether an *Osman*-style operational duty arose which required that she be taken to hospital, it is also necessary to take into account other countervailing factors relevant to her situation: see paras 57-60 above.

206. The care home was intended to be an environment in which Jackie's autonomy was promoted and she was treated with dignity and respect. It was important that she should have a good and cooperative relationship with her carers, which required trust. There were thus good reasons that, where possible, Jackie's own decisions and preferences should be given respect, although not treated as binding.

207. Also, as a general matter, healthcare professionals should seek to respect the autonomy of those in their care where possible and should at all times aim to act in their best interests, avoiding harm to them. Where an ambulance crew encounter a patient who is resistant to going to hospital, it is not a simple matter to say they must be forced to go either by means of physical restraint or by chemical restraint through the administration of sedatives. Both may have negative effects which harm the patient. An assessment is called for, to ensure that if such means are to be used, that is only where this is proportionate to the risk faced by the patient.

208. None of the healthcare professionals involved was on notice that Jackie's life was in danger, so as to engage the *Osman* operational duty. Furthermore, the paramedics, who had the ultimate decision about taking Jackie to hospital (albeit with the benefit of medical advice given by Dr Fairhead) gave proper consideration to the question whether she ought to be removed there and made an assessment which was reasonable in the circumstances, that the risk to her was not so great as to make that appropriate. At the inquest, the relevant expert witness (Dr Goode) did not criticise them for making this decision: para 103 above.

209. For these reasons, I consider that the appellant cannot maintain that there was any breach of the operational duty. The case does not fall within the "very exceptional circumstances" referred to in *Fernandes*, paras 190-191 (para 50 above). By the time of the verdict decision, this question had been thoroughly explored at the inquest and, particularly in the light of the expert evidence, there was no arguable case that there had been a breach of this duty. Again, it is telling that counsel for the family at the inquest did not contend that there was. Accordingly, I would reject the submission that the enhanced procedural obligation applied on the basis of an arguable breach of the operational duty by the healthcare professionals.

(8) The LDM Review and the CIPOLD report

210. I agree with the Court of Appeal, paras 103-104, that these materials do not support the appellant's case. As the Court of Appeal stated (para 104), "they do not illuminate how, when or where Jackie came by her death nor even in what circumstances she came by her death". They do not indicate that there was an arguable breach of either the systems duty or the operational duty in Jackie's case, so as to support the submission that the enhanced procedural obligation was applicable. In so far as it is suggested that these reports indicate in a very general way that more might be done to protect the health of individuals with learning disabilities, as was pointed out by the Strasbourg Court in *Fernandes*, para 175, it is not the proper role of the court to pronounce upon such matters, which involve judgments regarding allocation of scarce resources in the care and healthcare system.

(9) The Ullah principle

211. I have reached the conclusions above without the need to invoke the *Ullah* principle, as recently reaffirmed in this court in *R (AB) v Secretary of State for Justice* [2022] AC 487, paras 54-59. However, that principle certainly reinforces my view that the appellant's submissions based on article 2 do not succeed. This court cannot have any confidence that the Strasbourg Court would hold that the enhanced procedural obligation is applicable in this case, judged at the time of the verdict decision.

Conclusion

212. For the reasons set out above, I would dismiss this appeal.

LORD STEPHENS (concurring):

Lord Sales' judgment

213. It is right that I should commence by expressing my admiration for the judgment of Lord Sales, which I have read in draft. I am indebted to him for his close analysis of the authorities and of the relevant principles, and for his distillation of the many complex issues which arise in this difficult appeal. I agree with him that the appeal should be dismissed.

214. In this concurring judgment, I set out Jackie's personal circumstances to demonstrate her total dependence on others as to whether she should be treated at hospital. I will also briefly set out the relevant legal principles.

Jackie's personal circumstances

215. Jackie had lived in the care home since 1993. She had her own sitting room as she preferred to be on her own listening to music or watching the TV. She joined the other residents for meals. Jackie's mood was generally quite happy, so that she could be quite jovial, smiling and laughing. She did not demand to leave the care home. She accepted her medication. She would have been highly vulnerable in community settings.

216. Jackie was physically disabled due to a severe degree of kyphosis (spinal curvature). Jackie's back condition restricted her mobility. She required the assistance of two carers to go to bed or to come off her bed or chair. She was able to weight bear but could hardly walk for a few metres and for any longer distances she required a wheelchair. She spent a lot of time on the settee. She was required to take anti-inflammatory medication, Naproxen, 500 mg twice daily to manage back pain together with Ranitidine, 300 mg once daily, to manage the risk of gastric ulceration from the anti-inflammatory medication. She was also maintained on Paracetamol, 500 mg, as needed, four times a day.

217. In addition to her physical disability, Jackie had several mental disabilities. She had Down's Syndrome and moderate learning disability. Down's Syndrome is a frequent cause of intellectual disability and generally the IQ of individuals with Down's Syndrome lies between 20-50, although there is no specific figure for Jackie's IQ. Jackie's speech was restricted to a few words or very basic small sentences. She was very repetitive in her words. She generally said one word at a time. For instance, if she wanted juice she would say "juice" and point her finger towards the juice bottle. She was able to say simple words such as "yes" or "no". She had no insight into her psycho-social and cognitive deficits and harboured multi-dimensional vulnerabilities. She had no real understanding of her placement at the care home, and she was shallow and concrete in her thinking.

Jackie's mental capacity and deprivation of her liberty

218. On 7 April 2016, a Standard Authorisation was granted by Blackpool Council under Schedule A1 of the MCA 2005 to deprive Jackie of her liberty at the care home for the purpose of her being given the proposed care and/or treatment, as she was unable to make this decision because of an impairment of, or a disturbance in, the functioning of the mind or brain. The authorisation was based on Deprivation of Liberty Safeguards Form 3 ("Form 3") which included a mental capacity and best interests assessment. Form 3 was completed by John Davies Fryar, a social worker and best interests assessor, on 4 April 2016. The authorisation was also based on Deprivation of Liberty Safeguards Form 4 ("Form 4") which was a mental capacity, mental health,

and eligibility assessment completed by Dr Safdar Ali, a consultant psychiatrist on 27 March 2016.

219. To complete Form 3, Mr Fryar met and consulted with Sharon Simpson, the manager of the care home, Muriel Maguire, Jackie's mother, and Susan Egan, the senior support worker at the care home. He also considered the following three documents: a Care Plan dated 2 April 2016, a Daily Contact note, and Form 4 completed by Dr Ali and dated 4 April 2016. Under background information Mr Fryar recorded, amongst other matters, that:

> "[Jackie] has lived in this home for 15 years and therefore it should be considered as her home rather than a placement. … She has her own sitting room as she prefers to be on her own listening to music or watching the TV. She joins the other residents for meals. The staff provide her with a full range of activities and they take her out in her electric wheel chair to a variety of activities. … "

Under the heading "Views of the relevant person", Mr Fryar recorded that Jackie was able to tell him that she likes the home and he considered that she presented as very settled within the home. Under the heading "Views of Others", Mr Fryar recorded that staff told him that Jackie "needs one to one care in all her personal needs". On page 6 of Form 3, Mr Fryar gave his opinion that Jackie is to be kept in the care home for the purpose of being given the relevant care or treatment in circumstances that deprived her of liberty. In considering the objective of a deprivation of liberty, he referred to the objective of Jackie being "under constant supervision in the home" and gave his opinion that "given the size of the home, she can be easily observed by staff throughout the day". Another objective that could be met in the care home was that Jackie needed the help of staff in all her personal care. Significantly for the purposes of the issues in this appeal, he stated:

> "She is not prescribed any anti-psychotic or other sedative medication…. All other medication is administered by staff and [Jackie] does not have a choice as to whether she takes it."

Accordingly, one of the objectives was to make choices for Jackie in relation to her medication which could be achieved in the care home. In relation to each of these objectives he then stated that Jackie "is unable to consent to the above as, because of the lack of capacity, she is not orientated in place or

time". Accordingly, her lack of capacity extended not only to the decision as to whether to remain in the care home but also to other matters including her medication.

220. Jackie's lack of mental capacity in relation to her medical care is returned to under the heading "It is necessary to deprive the person of their liberty in this way in order to prevent harm to the person". One of the reasons given by Mr Fryar for depriving Jackie of her liberty was so that she received "her medication at the right time and in the right amount". Again, under the heading "This is in the person's best interests" one of the reasons given by Mr Fryar as to why it was in her best interests to be kept in the home for the purposes of being given the relevant care or treatment was that:

> "The home also makes sure she has appropriate and timely access to her GP and other NHS services."

Accordingly, Jackie was assessed by Mr Fryar as not only not having the mental capacity in relation to her medication but also as not having mental capacity to obtain appropriate and timely access to her GP or to other NHS services, such as an ambulance or a hospital. He considered that it was in her best interests to be detained in the care home so that the staff at the care home could make those decisions on her behalf. Mr Fryar again stated that deprivation of liberty at the care home was in her best interests because the staff at the care home could "administer her medication and make sure she receives it at the appropriate time and amount". As Jackie lacked mental capacity to make decisions as to her medical care, a part of the relevant care or treatment which justified the deprivation of her liberty was that the staff at the care home calling upon other healthcare providers would be responsible for such decisions.

221. Under the heading "It is necessary to deprive the person of their liberty in this way to prevent harm to the person", Mr Fryar also set out the harm that would occur to Jackie if she did not have her freedom restricted. Mr Fryar stated:

> "… she would be at risk from various factors in the outside environment. She would not be able to find her way back to the home, and she does not have a full grasp of the risks that road traffic provides to her. She would also be open to exploitation and at high risk of falls. …through various interventions, the home maintains [Jackie's] safety and welfare which,

> if she was living on her own, she would not be able to maintain for herself at an acceptable level. In her own home she would be at risk from everyday appliances."

222. On page 7 of Form 3, Mr Fryar stated that it was "totally inappropriate even to suggest alternatives to … [Jackie's] excellent placement …". On page 8 of Form 3, he gave his opinion that it was appropriate to deprive Jackie of her liberty under the Standard Authorisation for 12 months and that the Standard Authorisation should come into force as soon as possible.

223. In Form 4, Dr Safdar Ali gave his opinion that Jackie "lacks capacity to make her own decision about whether she should be accommodated in [the] care home for the purpose of being given the proposed care and/or treatment because of an impairment of, or a disturbance in the function of the mind or brain". In forming that opinion and in order to carry out a mental capacity assessment, Jackie, accompanied by Andrea, a member of the care home staff, was seen by Dr Ali in her room at the care home. An appropriate time was selected for the assessment when Jackie was fully active and alert. Dr Ali explained the purpose of the meeting in easy words, and Jackie was given sufficient time to understand and to give her responses. Dr Ali explained the nature of Jackie's illness to her together with its implication and merits of her staying at the care home. He also informed her of the potential problems if she decided not to stay at the care home. Dr Ali recorded that Jackie had no real understanding of his role or the reasons for his assessment. He considered that Jackie gave "little indication that she had ability to understand the relevance of her current care arrangements or the psychosocial factors which made these arrangements necessary". Dr Ali recorded that Jackie was quite jovial in her manners but appeared shallow in her thinking and was "childish in her behaviour". Dr Ali considered that Jackie was unable to retain information relevant to the decision as to whether she should be accommodated in the care home for the purpose of being given the proposed care and/or treatment. When asked about the information which had just been given to her "She just looked around". When asked to use or weigh the information as part of the process of making the decision "she just smiled". Dr Ali considered that Jackie was "a vulnerable adult with no insight". Dr Ali's assessment of Jackie's inability to understand and to retain information can be read across to her lack of mental capacity in relation to her own medical care.

224. Because of the assessments carried out by Mr Fryar and Dr Ali, Jackie was deprived of her liberty pursuant to the Deprivation of Liberty Safeguards set out in Schedule A1 to the MCA 2005. Consequently, the doors of the care home were kept locked and she was not permitted to leave without

supervision. The purpose of the authorisation was to enable the care or treatment to be given to Jackie as described by Mr Fryar in his best interests Form 3 which included medical care in liaison with the healthcare providers.

225. In conclusion, because of her mental and physical disabilities Jackie was totally dependent on others for her day-to-day care. Furthermore, she did not have the mental capacity to make any decision as to whether she should be treated at hospital. Any decision as to whether she should be treated at hospital was required to be made on her behalf by the staff at the care home and by the health care providers.

Jackie's fear of medical interventions

226. Jackie was fearful of medical interventions and sought to avoid them. She had refused a blood test in 2013. Her medical records noted that she would require diazepam (a sedative) and a home visit if an injection were ever required. In November 2016, Jackie refused to agree to her GP taking blood for a test as part of an investigation into stomach pain she was experiencing. In December 2016, she attended hospital for an ultrasound scan as part of that investigation, but this was not completed due to her becoming upset during the scan.

The risk to Jackie's life and her death

227. Lord Sales in the part of his judgment entitled "The Facts" has set out Jackie's symptoms in the period immediately prior to her death. For present purposes, the symptoms commenced on 16 February 2017 when it was noted that Jackie was not eating well and was complaining of a sore throat. She suffered from diarrhoea. On 20 February 2017 Jackie vomited and had a raised temperature. On 21 February 2017, Jackie was noted by care home support worker Susan Egan to be experiencing breathing difficulties. Jackie suffered a "possible collapsing episode" at 2.15 pm and had refused food and drink. By 3.36 pm, Ms Egan informed NHS 111 that Jackie had been vomiting and the vomit looked like coffee grounds (the medical significance of this is that coffee ground vomit is generally interpreted as a sign of vomiting blood). Jackie was also complaining of terrific pains in her stomach. At about 7 pm, Jackie collapsed at the bottom of the stairs on her way to bed and a member of staff was unable to say whether it was a faint or a fit. Two members of staff helped Jackie to the bathroom where she again collapsed. Ms Le Saint, one of the carers at the home, informed the 111 service that Jackie was warm to touch and had had a "crushing pain in her chest/upper abdomen in the last 24 hours. Pain within the last 12 hours, vomiting coffee grounds".

228. At the inquest, Dr Peter Goode, a consultant with expertise in emergency medicine, expressed the view that Jackie was on a sepsis pathway on 21 February 2017, at which time the risk of death was 30-40%. He opined that the risk of death had increased to 70% by the morning of 22 February 2017 when she was admitted to hospital.

229. On 21 February 2017, the staff at the care home and the healthcare providers did not have actual knowledge of the risk to Jackie's life nor did they have actual knowledge that the risk would increase dramatically if Jackie did not receive treatment in hospital. Jackie lacked the capacity to make decisions regarding her treatment and so it was decided for her that she should remain in the care home with someone checking on her during the night. However, if the care home staff and the healthcare professionals ought to have known of the risk to Jackie's life on 21 February 2017, then the preventative measure would have been to sedate Jackie or to lightly restrain her so that she could be taken to hospital for treatment. There would be no question of that preventative measure imposing an undue burden on the state authorities, nor would there be any question of any countervailing issues in relation to Jackie's dignity and personal autonomy weighing in the balance so that the preventative measure of taking her to hospital was unreasonable.

230. It is important at this stage to note that after all the evidence was heard at the inquest, Ms Formby, for Jackie's family, did not contend that there had been a breach of the *Osman* operational duty on the basis that the care home staff and the healthcare professionals ought to have known of the risk to Jackie's life on 21 February 2017. It is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. Accordingly, any omission by Ms Formby to submit that there was an arguable case of a breach of the substantive positive obligation on the basis that the care home staff and/or the healthcare providers knew or ought to have known of the risk to Jackie's life is not conclusive. However, those present at the inquest are best placed to understand the dynamics of the evidence and it is relevant that at the end of the evidence an arguable breach of an *Osman* duty was not being advanced on behalf of the family. Furthermore, it is relevant that the Coroner who had been immersed in the evidence did not consider that there was an arguable case of a breach of the substantive positive obligation on the basis that the care home staff and/or the healthcare providers knew or ought to have known of the risk to Jackie's life.

231. In the event, Jackie was not taken to hospital on 21 February 2017, and she remained in the care home.

232. On the morning of 22 February 2017, Jackie was found to have soiled her bedclothes. She was reluctant to get out of bed. When she did so she collapsed. Jackie was moved to the bathroom where she collapsed once more and appeared to suffer a seizure. She was unconscious on the bathroom floor. An ambulance was called, and the ambulance crew having concluded that Jackie lacked capacity to make decisions regarding her treatment, decided that it was in her best interests to use light physical restraint to take her to hospital. I would observe that nothing had altered in relation to Jackie's mental capacity. At all times she lacked capacity to make decisions regarding her treatment. What had changed was that by this time there was actual knowledge of the extreme nature of Jackie's condition. Jackie was secured to a carry-chair by her legs and was carried to the ambulance.

233. Jackie arrived at the Blackpool Victoria Teaching Hospital at 9.22 am on 22 February 2017 by which stage it was not possible to save her life. She died in the hospital at 7.40 pm on 22 February 2017 following a cardiac arrest.

234. Dr S Shaktawat, who conducted an autopsy on 28 February 2017, identified the cause of Jackie's death as being "1a. Perforated gastric ulcer with peritonitis. 2. Pneumonia." The ulcer which extended to 3 cm had perforated Jackie's stomach and resulted in peritonitis. According to the evidence at the inquest, it had developed over several months.

The issue at the inquest

235. At the inquest into Jackie's death, if there was an arguable case that there was a breach of a substantive positive obligation under article 2 of the Convention then, provided the case fell within the enhanced procedural obligation (see para 245 below), rather than the redress procedural obligation (see para 248 below), the Coroner was required to request the jury to return an expanded verdict in accordance with section 5(2) of the 2009 Act.

236. On 29 June 2018, the Coroner gave his verdict decision that article 2 did not require an expanded verdict. Whether the verdict decision was correct is under challenge in these proceedings.

Article 2: outline of the applicable legal framework

237. Article 2 provides:

> "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following

his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection."

238. Article 2 imposes a negative duty to refrain from taking life, save in the exceptional circumstances envisaged by article 2.2. Article 2 also imposes positive obligations on the state. I agree with Lord Sales in relation to the typical nomenclature adopted in respect of those positive obligations.

239. There are *substantive positive obligations* on a state to take steps to protect life and there are *procedural positive obligations* on a state regarding investigation of, and the opportunity to call state authorities to account for, potential breaches of substantive positive obligations.

240. I agree that the substantive positive obligations on a state to take steps to protect life are typically analysed as being of two types. First, *a systems duty* consisting of an obligation on the state to have appropriate legal regimes and administrative systems in place to provide general protection for the lives of citizens and persons in its territory. Second, an *operational duty* consisting of an obligation on the state to take preventative operational steps to protect a specific person or persons when the state knew or ought to have known of a risk to life; see *Osman v United Kingdom* 29 EHRR 245 and *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72.

241. Lord Sales states that such an operational duty arises when the state is "on notice that [the specific person or persons] are subject to a risk to life of a particularly clear and pressing kind"(para 10 above). However, the criterion is a "real and immediate" risk to life. A real risk is one that is objectively verified

and an immediate risk is one that is present and continuing; see *In re Officer L* [2007] 1 WLR 2135, at para 20. Lord Carswell in *Re Officer L* added that:

> "It is in my opinion clear that the criterion is and should be one that is not readily satisfied: in other words the threshold is high."

Those additional words were considered in *Van Colle v Chief Constable of Hertfordshire Police* [2009] AC 225. Lord Hope in referring to Lord Carswell's words stated at para 66:

> "I read his words as amounting to no more than a comment on the nature of the test which the Strasbourg court has laid down, not as a qualification or a gloss upon it. We are fortunate that, in the case of this vitally important Convention right, the Strasbourg court has expressed itself in such clear terms. It has provided us with an objective test which requires no further explanation. The question in each case will be whether on the facts it has been satisfied."

Lord Bingham also referred to Lord Carswell's words at para 30. Lord Bingham stated that "… the test formulated by the Strasbourg court in *Osman* and cited on many occasions since is clear and calls for no judicial exegesis". I would caution that there should not be a domestic gloss on the Strasbourg criterion by using the phrase of "a particularly clear and pressing kind" in relation to "real and immediate risk".

242. I agree that the procedural positive obligations on a state regarding investigation of, and the opportunity to call state authorities to account for, potential breaches of substantive positive obligations varies according to context.

243. I also agree that for present purposes there are three levels of the graduated procedural positive obligation.

244. First, the *basic procedural obligation* under which state authorities should take some steps to establish whether the cause of death is from natural causes rather than, say as a result of criminal means such as violence or other foul play.

245. Second, the *enhanced procedural obligation*. Lord Sales states that under this enhanced procedural obligation "a state may be required to take the initiative to take further steps to investigate possible breaches of the substantive obligations imposed by article 2 …" (para 15 above). I consider that if the enhanced procedural obligation applies then the state *is* required to take the initiative. The state authorities must act of their own motion once the matter has come to their attention. They cannot, for instance, leave it to the initiative of the next of kin.

246. The enhanced procedural obligation automatically applies in certain categories of cases, such as where state agents have used lethal force, see *McCann v United Kingdom* 21 EHRR 97. It also applies in circumstances where there is an arguable breach of the state's substantive positive obligations which are for present purposes the systems duty and/or the operational duty.

247. Until an inquest is underway, and the real issues can be identified, there may be no proper way in which an assessment can be made as to whether there is an arguable breach of the state's substantive positive obligations so as to engage the enhanced procedural obligation. Accordingly, the Coroner will properly, as in this case, proceed on the basis that there is a need for an expanded verdict and then review the position at the end of the evidence, by which stage most if not all of the additional costs of the inquest have been incurred. Therefore, it is apparent that it will rarely be the case that the positive enhanced procedural obligation will impose an unreasonable or disproportionate burden on the state in relation to the conduct of an inquest.

248. Third, the *redress procedural obligation* which has been typically applied in cases involving possible breaches of article 2 in the context of provision of medical services, where it is alleged that there has been negligence by medical practitioners. In such circumstances, even though there is a possibility that the substantive obligations in article 2 have been breached, the procedural obligation is limited to a combination of the basic procedural obligation and the redress procedural obligation. As Lord Sales states, those procedural obligations will be "satisfied by a combination of the holding of an inquest to determine the cause of death, without any requirement of an expanded verdict, and the availability of a civil claim for damages for negligence" (para 20 above).

Application of the legal principles to the facts of this appeal

249. Lord Sales has carefully and exhaustively analysed whether there was an arguable breach of the systems duty or the operational duty on the part of either the care home or the healthcare providers. I agree with his conclusions.

Conclusion

250. I would dismiss the appeal.